For the most up-to-date and accurate Medicaid rules, please go to the Secretary of State's website.

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Chapter 10 - EOHHS General Provisions

Subchapter 00 - Overview of the Rhode Island Medicaid and Children's Health Insurance Programs (210-RICR-10-00-1)

1.1 Statutory Authority of the State Agency

A. R.I. Gen. Laws § 42-7.2-2 created the Rhode Island Executive Office of Health and Human Services (EOHHS) in 2006. EOHHS serves "as the principal agency of the executive branch of state government for managing the departments of children, youth and families, health, human services, and behavioral healthcare, developmental disabilities and hospitals."

B. EOHHS is responsible for administering the State's Medicaid program, which provides health care services and supports to a significant number of Rhode Islanders on an annual basis.

C. The statutory foundations of the Rhode Island Medicaid program are Title XIX of the Social Security Act (42 U.S.C. § 1396a *et seq*.), R.I. Gen. Laws Chapter 40-8, and R.I. Gen. Laws Chapter 42-7.2. Statutory authority for health care coverage funded in whole or in part by the federal Children's Health Insurance Program (CHIP) is derived from 42 U.S.C. § 1397aa *et seq*., of the U.S. Social Security Act, which establishes that program and provides the legal basis for providing health coverage, services and supports to certain targeted low-income children and pregnant women through Medicaid.

D. EOHHS is designated as the "single state agency", authorized under Title XIX and, as such, is legally responsible for the fiscal management and administration of the Medicaid program. As health care coverage funded by CHIP is administered through the State's Medicaid program, EOHHS also serves as the CHIP State Agency under federal and State laws and regulations.

E. The Medicaid and CHIP State Plans and the Rhode Island's Medicaid Section 1115 demonstration waiver provide the necessary authorities for the health care administered through the Medicaid program and establish the respective roles and responsibilities of beneficiaries, providers, and the State.

1.2 Definitions

A. As used herein, these definitions have the following meaning:

1. "CHIP State Plan" means the State of Rhode Island's State Plan identifying the eligibility categories and services authorized for federal financial participation under Title XIX of the federal Social Security Act establishing the Children's Health Insurance Program (CHIP).

2. “Executive Office of Health and Human Services" or "EOHHS” means the state agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 within the executive branch of state government and serves as the principal agency for the purposes of managing the Departments of Children, Youth, and Families (DCYF); Health (RIDOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). EOHHS is designated as the “single state agency,” authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

3. “Medicaid State Plan” means State of Rhode Island’s State Plan identifying the eligibility categories and services authorized for federal financial participation under Title XIX of the federal Social Security Act establishing the Medicaid program.

4. “State agency” means EOHHS.

1.3 Purposes and Scope of the Medicaid Program

A. The Rhode Island Medicaid program is the joint federal/state health care program that provides publicly funded health coverage to low-income individuals and families, adults without dependent children age nineteen (19) to sixty-four (64), elders, and persons with disabilities who otherwise cannot afford or obtain the services and supports they need to live safe and healthy lives.

B. Eligibility -- Coverage Groups. A coverage group is a classification of individuals eligible to receive Medicaid benefits based on a shared characteristic such as age, income, health status, and level of need criteria. Pursuant to the authority provided under the Medicaid and CHIP State Plans and the State’s Section 1115 demonstration waiver, health coverage, services, and supports are available to individuals and families who meet the eligibility requirements for the following coverage groups:

1. Medicaid Affordable Care Coverage (MACC) Groups –A single income standard – Modified Adjusted Gross Income or “MAGI” – must be used to determine the eligibility of all applicants under the Medicaid affordable care coverage groups, which are as follows:

a. Families with children and young adults, pregnant women, infants and parents/caretakers with income up to the levels sets forth in Part 30-00-3 of this Title;

b. Adults between the ages of nineteen (19) and sixty-four (64) without dependent children who meet the income limits set forth in the Part 30-00-3 of this Title, including any persons in this age group who are awaiting a determination of eligibility for Medicaid on the basis of age, blindness, or disability pursuant to Part 40-05-1 or receipt of Supplemental Security Income (SSI) pursuant to Part 40-00-3 of this Title;

2. Integrated Health Care Coverage (IHCC) Groups – All applicants for Medicaid who must meet both clinical and financial eligibility requirements or who are eligible based on their participation in another needs-based, federally funded health and human services program are not subject to the MAGI. The State has reclassified these categorically and medically needy populations into coverage groups based on shared eligibility characteristics, level of need, and/or access to integrated care options as follows:

a. Adults between the ages the ages of nineteen (19) and sixty-four (64) who are blind or disabled and elders age sixty-five (65) and older who meet the financial and clinical eligibility for Medicaid-funded coverage established pursuant Part 40-05-1 of this Title;

b. Persons of any age who require long-term services and supports in an institutional or home and community-based setting who meet the financial and clinical criteria established pursuant to the Parts 50-00-6 and 50-00-5 of this Title, respectively, or in the case of children eligible under the Katie Beckett provision, who meet the criteria in the Part 50-10-3 of this Title;

c. Individuals eligible for Medicaid-funded health coverage on the basis of their participation in another publicly funded program including children and young adults receiving services authorized by the Department of Children, Youth and Families and persons of any age who are eligible on the basis of receipt of SSI benefits.

d. Medically needy individuals who meet all the eligibility criteria for coverage except for excess income. Individuals in this coverage group achieve eligibility by applying a flexible test of income which applies excess income to certain allowable medical expenses thereby enabling the individual to "spend down" to within a medically needy income limit (MNIL) established by the Medicaid agency.

e. Low-income elders and persons with disabilities who qualify for the Medicare Premium Payment Program (MPP) authorized by the Title XIX. Medicaid pays the Medicare Part A and/or Part B premiums for MPP beneficiaries.

C. Benefits. Medicaid beneficiaries are eligible for the full scope of services and supports authorized by the Medicaid State Plan and the Section 1115 demonstration waiver.

1. General scope of coverage. Although there is variation in benefits by coverage group, in general Medicaid health coverage includes the following:

Doctor's office visits	Home health care
Immunizations	Skilled nursing care

Prescription and over-the-counter medications

Lab tests

Residential treatment

Behavioral health services

Drug or alcohol treatment

Early and Periodic, Screening, Detection and Treatment (EPSDT)

Referral to specialists

Hospital care

Emergency care

Urgent Care

Long-term Services and Supports (LTSS) in home and community-based and health care institutional settings such as nursing homes

Nutrition services

Interpreter services

Childbirth education programs

Prenatal and post-partum care

Parenting classes

Smoking cessation programs

Transportation services

Dental care

Expedited LTSS

Organ transplants

Durable Medical Equipment

2. EPSDT. Title XIX authorizes Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for all Medicaid beneficiaries who are under age twenty-one (21) for the purposes of identifying and treating behavioral health illnesses and conditions. Medically necessary EPSDT services must be provided irrespective of whether they are within the scope of Medicaid State Plan covered services.

3. Limits. Certain benefits covered by the Medicaid State Plan or the State's Section 1115 waiver are subject to limits under federal and/or State law. Program-wide benefit limits are set forth in § 1.5 of this Part. Limits and restrictions applicable to specific coverage groups are located in the rules describing the coverage group and service delivery.

1.4 Program Administration

A. Applications and Eligibility. EOHHS implements a "no wrong door" policy to ensure persons seeking eligibility for Medicaid health care coverage have the option to apply at multiple locations throughout the State and in a manner that is best suited to their needs including, but not limited to, in-person, on-line, by telephone, or by U.S. mail. Application and eligibility information for the MACC groups is located in the Part 30-00-3 of this Title. An overview of the application process for the IHCC groups is located in Part 40-00-1 of this Title.

1. Determinations. EOHHS must make timely and efficient eligibility, enrollment, and renewal decisions. Accordingly, EOHHS or an entity designated by the Secretary for such purposes must review and make eligibility and renewal determinations for Medicaid health care coverage in accordance with applicable State and federal laws, rules, and regulations.

2. Timeliness. In general, determinations must be made in no more than thirty (30) days from the date a completed application is received by EOHHS or its designee unless clinical eligibility factors must be considered. In instances in which both clinical and financial eligibility factors are material to the application process, as for eligibility for Medicaid-funded LTSS or coverage for persons with disabilities, determinations must be made in ninety (90) days. Applicable time-limits and other eligibility requirements are set forth in the Rhode Island Code of Regulations, Title 210, in the chapters related to each population Medicaid serves by eligibility coverage groups.

3. Cooperation. As a condition of eligibility, the Medicaid applicant/ beneficiary must meet certain cooperation requirements, such as providing the information needed for an eligibility determination, taking reasonable action to make income or resources available for support, assigning of rights to medical support or other third-party payments for medical care, or pursuing eligibility for other benefits. Failure to cooperate may result in a denial or termination of eligibility.

B. Eligibility Agent -- DHS. The Medicaid State Agency is authorized under Title XIX and federal implementing regulations to enter into agreements with other State agencies for the purposes of determining Medicaid eligibility. EOHHS has entered into a cooperative agreement with the Rhode Island Department of Human Services (DHS) that authorizes the DHS to conduct certain eligibility functions. In accordance with 42 C.F.R. § 431.10 (e)(3), the DHS has agreed to carry out these functions in accordance with the Medicaid State Plan, the State's Section 1115 demonstration waiver, and the rules promulgated by EOHHS.

C. Written Notice. EOHHS is responsible for notifying an applicant, in writing, of an eligibility determination. If eligibility has been denied, the notice to the applicant sets forth the reasons for the denial along with the applicable legal citations and the right to appeal and request a fair hearing. The Appeals Process and Procedures for EOHHS Agencies and Programs (Subchapter 05 Part 2 of this Chapter) regulations describe in greater detail the appeal and hearing process.

D. Mandatory Managed Care Service Delivery. To ensure that all Medicaid beneficiaries have access to quality and affordable health care, EOHHS is authorized to implement mandatory managed care delivery systems. Managed care is a health care delivery system that integrates an efficient financing mechanism with quality service delivery, provides a medical home to assure appropriate care and deter unnecessary services, and places emphasis on preventive and primary care. Managed care systems also include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the Medicaid agency.

Managed care systems include the Medicaid program's integrated care options such as long-term services and supports and primary care health coverage for eligible beneficiaries. The managed care options for Medicaid beneficiaries vary on the basis of eligibility as follows:

1. Families with children eligible under the Part 30-00-1 of this Title are enrolled in a RIte Care managed care plan in accordance with the Part 30-05-2 of this Title or, as applicable, an employer health plan approved by EOHHS for the RIte Share Premium Assistance Program in accordance with the Part 30-05-3 of this Title unless specifically exempted;

2. Adults ages nineteen (19) to sixty-four (64) eligible in accordance with the Part 30-00-1 of this Title are enrolled in a Rhody Health Partners managed care plan in accordance with the Part 30-05-2 of this Title or, as applicable, an employer health plan approved by EOHHS for the RIte Share premium assistance program in accordance with the Part 30-05-3 of this Title unless specifically exempted;

3. Elders and adults who are blind or living with a disability and between the ages of nineteen (19) and sixty-four (64) eligible pursuant to Part 40-05-1 of this Title are enrolled in a Rhody Health Partners plan or Connect Care Choice primary care case management practices in accordance with Part 40-10-1 of this Title.

4. Persons eligible for Medicaid-funded long-term services and supports in accordance with the Part 50-00-1 of this Title have the choice of self-directed care, fee-for-service, or enrolling for services in PACE, Rhody Health Options, or Connect Care Choice Community Partners in accordance with Part 40-10-1 of this Title.

5. Persons eligible as medically needy or as a result of participation in another publicly funded health and human services program may be enrolled in fee-for-service or a managed care plan depending on the basis of eligibility. See exemptions in the Part 30-05-2 of this Title "RIte Care Program" Part 30-05-2 of this Title and Part 40-10-1 of this Title related to coverage group.

E. Waiver eligibility and services. Until 2009, the Medicaid program utilized authorities provided through its RIte Care Section 1115 and multiple Title 1915(c) waivers to expand eligibility and access to benefits beyond the scope provided for in the Medicaid State Plan. At that time, the State received approval from the Secretary of the U.S. Department of Health and Human Services (DHHS) to operate the Rhode Island Medicaid program under a single Section 1115 demonstration waiver. All Medicaid existing Section 1115 and Section 1915(c) waiver authorities have been incorporated into the Medicaid program-wide Section 1115 demonstration waiver, as it has been renewed and extended, since it was initially approved in 2009.

1.5 Program-wide Limits and Restrictions

A. Both federal and State law impose certain limits and restrictions on the scope, amount, and duration of the health care coverage, services, and supports financed and administered through the Medicaid program.

B. Benefits authorized under the Medicaid State Plan and the State's Sections 1115 demonstration waiver are limited as follows:

1. Termination of pregnancy. The deliberate termination of a pregnancy – or an abortion – is only a paid Medicaid service when the pregnancy is the result of an act of rape or incest or the termination is necessary to preserve the life of the woman. The treating physician performing the procedure must submit to EOHHS along with a request for payment a sworn, written statement certifying that:

a. the woman's pregnancy was the result of rape or incest or

b. the termination was necessary to save the life of the mother. A copy of this letter must be maintained in the woman's patient record for a period of no less than three (3) years. In cases of rape or incest, the woman receiving the termination procedure must also submit a sworn statement to EOHHS attesting that her pregnancy was the result of rape or incest. This requirement may be waived if a treating physician certifies that the woman is unable for physical or psychological reasons to comply. The procedure must be performed by a Rhode Island licensed physician in an appropriately licensed hospital-setting or out-patient facility.

2. Organ Transplant Operations. Medicaid provides coverage for organ transplant operations deemed to be medically necessary upon prior approval by EOHHS.

a. Medical necessity for an organ transplant operation is determined on a case-by-case basis upon consideration of the medical indications and contraindications, progressive nature of the disease, existence of alternative therapies, life threatening nature of the disease, general state of health of the patient apart from the particular organ disease, any other relevant facts and circumstances related to the applicant and the particular transplant procedure.

b. Prior Written Approval of the Secretary or his/her designee is required for all covered organ transplant operations. Procedures for submitting a request for prior approval authorizations are available through the provider portal on the EOHHS website at: www.eohhs.ri.gov/providers.

c. Authorized Transplant Operations provided as Medicaid services, upon prior approval, when certified by a medical specialist as medically necessary and proper evaluation is completed, as indicated, by the transplant facility as follows:

(1) Certification by medical specialist required -- kidney transplants, liver transplants, corneal transplants, and bone marrow transplants.

(2) Certification by an appropriate medical specialist and evaluation at the transplant facility - pancreas transplants, lung transplants, heart transplants, heart/lung transplants.

d. Other Organ Transplant Operations as may be designated by the Secretary of EOHHS after consultation with medical advisory staff or medical consultants.

3. Pharmacy Services for Dual Eligible Beneficiaries. Under federal law, states providing a Medicaid-funded pharmacy benefit must extend or restrict coverage and co-pays to beneficiaries eligible for both Medicaid and Medicare as follows:

a. Medicare Part D Wrap. Medicaid beneficiaries who receive Medicare Part A and/or Part B, qualify for Part D and must receive their pharmacy services through a Medicare-approved prescription drug plan. Therefore, these dually eligible Medicaid-Medicare beneficiaries are not eligible for the Medicaid pharmacy benefits. There are, however, certain classes of drugs that are not covered by Medicare Part D plans. Medicaid coverage is available to those receiving Medicare for these classes of drugs. The classes of drugs covered by Medicaid are: vitamins and minerals (with the exception of prenatal vitamins and fluoride treatment), Medicaid-approved over-the-counter medications, cough and cold medications, smoking cessation medications, and covered weight loss medications (with prior authorization). When purchasing these classes of drugs, Medicaid beneficiaries are required to pay a co-payment of one dollar ($1.00) for generic drug and three dollars ($3.00) for a brand name drug prescription.

b. Medicare Part D Cost-sharing Exemption. There is no Medicare Part D cost-sharing for full benefit Medicaid-Medicare dual eligible beneficiaries who would require the level of services provided in a long-term health facility if they were not receiving Medicaid-funded home and community-based services under Title XIX waiver authority, the Medicaid State Plan, or through enrollment in a Medicaid managed care organization. To obtain the cost-sharing exemption, the Medicare Part D plan sponsor must receive proof of participation in one of the following Medicaid-funded home and community-based services programs: Preventive/Core Services, Personal Choice, Habilitation, Shared Living, and Assisted Living as well as the co-pay program administered by the Division of Elderly Affairs (DEA).

C. Federal law and regulations authorize the Medicaid agency or its authorized contractual agent (managed care plan/organization) to place appropriate restrictions on a Medicaid-funded benefit or service based on such criteria as medical necessity or on

utilization control (42 C.F.R. § 440.230(d)). The Medicaid "Pharmacy Home" lock-in Program was established under this authority to restrict access to full pharmacy services in instances in which there is documented excessive use by a beneficiary. Beneficiaries are "locked-in" to specific providers in order to monitor services received and reduce unnecessary or inappropriate utilization. This program is intended to prevent Medicaid beneficiaries from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies. Additional information on the Pharmacy Home Lock-in Program is contained in Part 30-05-2 ("Managed Care Delivery Options") of this Title.

1.6 Cooperation Requirements

As a condition of eligibility, the Medicaid applicant/ beneficiary must meet certain cooperation requirements, such as providing the information needed for an eligibility determination, taking reasonable action to make income or resources available for support, assigning of rights to medical support or other third-party payments for medical care, or pursuing eligibility for other benefits. Failure to cooperate may result in a denial of eligibility or case closure.

1.7 Direct Reimbursement to Beneficiaries

A. Some individuals, while appealing a determination of Medicaid ineligibility, incur and pay for covered services. Direct reimbursement may be available to beneficiaries in certain circumstances. Direct reimbursement is available to such individuals if, and only if, all of the following requirements are met:

1. A written request to appeal a denial or discontinuance of Medicaid coverage is received by the State within the time frame specified in the) "Appeals Process and Procedures for EOHHS Agencies and Programs" (Subchapter 05 Part 2 of this Chapter) regulations.

2. The original decision to deny or discontinue Medicaid coverage is reversed on appeal by the Appeals Officer or by the Regional Manager or Chief Supervisor/Supervisor).

3. Reimbursement is only available if the original decision was reversed. Reimbursement is not made, for example, if the original decision is reversed because information or documentation, not provided during the application period, is provided at the time of the appeal.

4. The beneficiary submits the following:

a. A completed Application for Reimbursement form;

b. A copy of the medical provider's bill or a written statement from the provider which includes the date and type of service;

c. Proof of the date and amount of payment made to the provider by the beneficiary or a person legally responsible for the beneficiary. A cash receipt, a copy of a canceled check or bank debit statement, a copy of a paid medical bill, or a written statement from the medical provider may be used as proof of payment, provided the document includes the date and amount of the payment and indicates that payment was made to the medical provider by the beneficiary or a person legally responsible for the beneficiary.

5. Payment for the medical service was made during the period between a denial of Medicaid eligibility and a successful appeal of that denial. That is, payment was made on or after the date of the written notice of denial (or the effective date of Medicaid termination, if later) and before the date of the written decision issued by the EOHHS Appeals Office, or decision by the Regional Manager/Chief Casework Supervisor after, reversing such denial is implemented (or the date Medicaid eligibility is approved, if earlier).

1.8 Procedure and Notification

A. Notices of Medicaid ineligibility provide applicants and beneficiaries with information about their rights to appeal the agency's decision. These notices also contain specific information about the availability of direct reimbursement if a written appeal is filed and the State's initial decision is overturned as incorrect. The rules governing appeals and hearings are located in "Appeals Process and Procedures for EOHHS Agencies and Programs" (Subchapter 05 Part 2 of this Chapter) regulations.

B. The EOHHS Appeals Office must provide individuals who may qualify with an Application for Reimbursement form to request repayment for medical expenses which they incurred and paid while their appeal was pending.

C. The individual must complete and sign the Application for Reimbursement form and include: a) a copy of the provider's bill showing date and type of service; and b) proof that payment was made by the beneficiary or a person legally responsible for the beneficiary between the date of the erroneous denial and the date of the successful appeal decision. The completed form and required documentation is returned to the appropriate department representative.

D. If either the bill or proof of payment is not included with the Application form, the Medicaid agency representative offers to assist the beneficiary in obtaining the required documentation and sends a reminder notice requesting return of the required information within thirty (30) days from the date of receipt of the Application for Reimbursement form. If all documents are not received within thirty (30) days, or if the documentation provided indicates that medical service or payment was not made between the date of Medicaid denial (or termination) and the date of Medicaid acceptance (or reinstatement), the agency representative denies the request for reimbursement.

E. Otherwise, the agency representative forwards a referral form, attaching the beneficiary's written request for reimbursement and all supporting documentation to the Medicaid agency for a decision on payment. The Medicaid agency is responsible for providing the individual with written notification of the agency's decision and rights to appeal.

EOHHS General Provisions

Subchapter 00 - Medicaid and Children's Health Insurance Program (CHIP) Non-Financial General Eligibility Requirements (210-RICR-10-00-3)

3.1 Overview

A. In accordance with Title XIX and XXI (42 U.S.C. §§ 1396a and 1396k), all Medicaid applicants and beneficiaries must meet certain non-financial general eligibility requirements related to: identity, date of birth/age, Social Security Numbers (SSNs), residency, U.S. citizenship, and immigrations status. In addition, certain applicants must agree to meet cooperation requirements. The scope of the cooperation requirements varies depending on eligibility category and the age of the applicant or beneficiary and may pertain to medical and child support, liens and estate recovery, providing application information, and reporting changes among others.

B. The provisions set forth herein are included in the State's plan for ensuring compliance with these and related federal requirements and are designed to promote ease of access to Medicaid while preserving program integrity. Toward this end, the State uses electronic data matches to the full extent possible to verify required information and limits the requests for supporting documentation to instances in which discrepancies between information sources are detected or electronic verification fails unless explicitly directed otherwise by federal or State law.

3.2 Scope and Purpose

A. This rule identifies the non-financial eligibility requirements for Medicaid and CHIP-funded health coverage administered through the RI Medicaid program. The rule also cites the location in this Title of any other more specific or additional, related provisions. Lastly, the rule sets forth the respective roles and responsibilities of both the State and applicants and beneficiaries in ensuring information about these requirements is obtained in the most efficient and least burdensome way that Rhode Island's integrated eligibility system (IES) allows within the parameters established in federal law.

B. Provisions related to the verification of financial eligibility are set forth as follows: Part 30-00-5 of this Title, for children, families, and ACA expansion adults who are evaluated using the Modified Adjusted Gross Income (MAGI) standard and children deemed eligible on the basis of participation in other federal programs; and Part 40-051 of this Title for elders and adults with disabilities who are subject to the Supplemental Security Income (SSI) method for determining financial eligibility for Community Medicaid and Medicaid long-term services and supports (LTSS).

3.3 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(dd), and 1903(v)(4); Title XXI of the Social Security Act, 42 U.S.C. § 1396k; Section 2107(e)(1)(j) and 2111 and Section 1111 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Pub. Law 111-3); Sections 401, 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (Pub. Law 104-193); Section 6036 of the Deficit Reduction Act of 2005 (Pub. Law 109-171);

2. Federal Regulations: 42 C.F.R. §§ 435.406, 435.945-949 and 440.250-255;

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; 40-8.4 to 40-8.12; and 42-12.3.

C. The rules in this Part supersede Medicaid Code of Administrative Rules (MCAR), Section #0304, "Technical Eligibility Requirements", unless otherwise indicated, pertaining to all Medicaid eligibility coverage groups and pathways.

3.4 Definitions

A. As used herein, the following terms shall be construed as follows:

1. "CHIP State Plan" means the State of Rhode Island's State Plan identifying the eligibility categories and services authorized for federal financial participation under Title XIX of the federal Social Security Act establishing the Children's Health Insurance Program (CHIP).

2. "Immigrant" means a non-citizen who has been granted the right by the United States Citizenship and Immigration Service (USCIS) to reside permanently in the United States and to work without restrictions in the United States. Such a person is also known as a Lawful Permanent Resident (LPR). All immigrants are eventually issued a "green card" (USCIS Form I-551), which is the evidence of the non-citizen's LPR status.

3. "Lawfully present" means the status of a non-citizen who has been granted permission to remain in the United States by the USCIS. This status includes immigrant qualified non-citizens who would otherwise be eligible for Medicaid or CHIP coverage if were not for the federal five (5) year bar and certain non-immigrants with visas who have been granted permission to live and/or work in the U.S. for a specific purpose and/or on a time-limited basis.

4. "Lawfully residing" means the eligibility category established under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 that gives states the option to provide coverage to a non-citizen children and pregnant

women who is are lawfully present and would otherwise be subject to the federal five (5) year bar.

5. “Medicaid State Plan” means State of Rhode Island’s State Plan identifying the eligibility categories and services authorized for federal financial participation under Title XIX of the federal Social Security Act establishing the Medicaid program.

6. “National” means a person who owes his or her sole allegiance to the United States, including all U.S. citizens, and persons who were born in American Samoa or were born in the Commonwealth of the Northern Mariana Islands who have chosen to be U.S. nationals instead of U.S. citizens.

7. “Non-citizen” means a person who is not a U.S. citizen or national.

8. “Nonimmigrant” means a person who has been granted the right to reside temporarily in the United States for a specific purpose. Each nonimmigrant is admitted into the U.S. in the nonimmigrant status which corresponds to the type of visa issued. The type of visa issued determines whether the nonimmigrant is treated as qualified or non-qualified for federal means-tested benefit eligibility purposes.

9. “Non-qualified non-citizen” means a nonimmigrant who is not eligible for federal means tested benefits, an immigrant who is out-of-status, or a non-citizen who has entered the United States illegally or without proper documentation.

10. "Qualified” or “Non-qualified non-citizens" means the terms used in federal immigration law to categorize immigrant and nonimmigrant non-citizens. The terms do not by themselves indicate whether an immigrant is eligible for benefits. "Qualified", "non-qualified" and undocumented non-citizens may be eligible for some forms of federally-funded benefits.

11. “United States (U.S.) citizens” means a person who is born in the United States, Puerto Rico, Guam or the U.S. Virgin Islands; or whose parent is a U.S. citizen; or who is a former non-citizen who has been naturalized as a U.S. citizen.

3.5 Attestations, Consent and Identity Proofing

A. Attestations and consent. In accordance with federal regulations at 42 C.F.R. § 435.945, when reviewing non-financial eligibility requirements, the State generally accepts: self-attestation when the person completing the application is requesting eligibility; and attestation by an adult who is in the applicant's household or family, or who is acting as an authorized representative, when the person requesting eligibility is a minor or incapacitated.

1. Application signature - To attest to the truthfulness of the information provided, an application must be signed either electronically or manually when submitted to

be considered valid. The State notifies an applicant when a signature is missing and held in pending status until the State receives the required signature from the applicant/head of household. If the application or appropriate sections or proxies thereof are not returned with a signature by the date due, the application is closed and no further action is taken by the State.

2. Consent for electronic data matches - Applicants are asked to provide consent for the State to conduct electronic data matches related to income and other non-financial eligibility factors at the time of application. Refusal to provide such consent does not constitute non-cooperation and, as such, cannot alone result in the denial of eligibility. The State will proceed with an eligibility determination without the applicant's consent. However, without this consent, the application processing time may increase and the State may require applicants to provide supplemental forms of paper documentation to support attestations and self-attestations for persons seeking Medicaid eligibility in the household.

B. Identity proofing. Identity proofing is a mechanism for assuring that an applicant is who he or she claims to be. This assurance is required to query the federal and State electronic databases necessary to verify attestations. In addition, these sources contain confidential, or private information that is protected by law and can only be obtained by and disclosed to the applicant subsequent to identity proofing. Therefore, identity proofing is required for anyone seeking affordable health coverage financed by Medicaid, federal tax credits, and/or state subsidies through a state eligibility system or health insurance exchange based on the Modified Adjusted Gross Income (MAGI) methodology.

1. Applicant's responsibilities - Applicants for Medicaid Affordable Care Coverage (MACC) eligibility under Chapter 30, who are subject to MAGI eligibility determinations, must comply with the provisions for establishing an on-line account set forth in Part 30-00-3.14 of this Title unless choosing to apply using a paper application. The identity proofing process occurs in conjunction with the creation of an account.

a. Beginning the process. The identify proofing process must be completed prior to the start of an on-line application by an adult acting as the head of the household or as authorized representative in the case of minors. The process involves answering a series of questions about a variety of personal matters including current and past residences, place of birth and so forth.

b. Alternative forms of proof. If the electronic process does not provide the required level of proof, an applicant may upload into his or her account or submit by fax, mail, or in-person, any of the forms of documents listed in § 3.9 of this Part:

2. State responsibilities -- Identity proofing is conducted as an electronic process and occurs in conjunction with the creation of account.

a. Remote Identity Proofing (RIDP). This process is conducted by a federal contractor in accordance with nationwide standards. The applicant's responses to questions related to identity are evaluated using a multifaceted authentication process. Once the proofing process is completed, the on-line application process may begin and access personal information held by trusted sources like the Social Security Administration, the Internal Revenue Service, and the Department of Homeland Security. This information becomes available to both the applicant and the State in real-time rather than after the application is submitted.

b. Agency assistance and alternative forms of proof. The State must provide assistance upon request to aid in both creating an account and in facilitating identity proofing for applicants who are unable to obtain the required level of verification through the RIDP process. In addition, the State must make applicants aware of and accept the alternative forms of identity proof identified in § 3.9 of this Part.

c. Limits. The identity proofing process is permitted only at the time of initial account creation. The State is prohibited from requiring a beneficiary to repeat the process during post-eligibility reviews or at the time of renewal. The State must also provide applicants with assurances that the identity proofing process, which is conducted by a credit rating agency, does not affect an applicant's credit standing or is not treated as a credit, rather than an identity check, for the purposes of establishing an application account.

3.6 Non-financial Eligibility Factors

A. Self-attestations and attestations at the time of initial application are accepted for certain non-financial eligibility requirements. Verification of this information is required in some by federal or state law or regulation, as indicated in § 3.6(B) of this Part below. Rhode Island has opted to utilize approved federal and State electronic interfaces with the IES for verification purposes when available, as authorized in 42 C.F.R. §§ 435.948 through 435.956. Paper documentation is therefore utilized only in instances when there is no information available through an electronic data source or there is a discrepancy between a self-attestation or an attestation and the electronic data source.

B. All persons seeking Medicaid eligibility must provide a date of birth (age) and an SSN. Attestations and self-attestations about Rhode Island residency are accepted and require no verification, However, attestations and self-attestations about age and SSN are verified through electronic data sources. All applicants must provide an SSN, show proof that one has been requested, or seek the assistance of an agency representative to apply for one before a determination of eligibility can be made.

1. Information and verification by coverage category -- The respective responsibilities of applicants and the State associated with non-financial eligibility

factors such as SSN and residency may vary by category of coverage. Accordingly, the applicable provisions are set forth in the Chapters of this Title related to each category of coverage, as indicated below:

a. Medicaid Affordable Care Coverage (MACC) Groups and Non-MAGI eligible children and youth. Required information and verification for families, children, ACA expansion adults and pregnant women whose eligibility is determined using the MAGI standard is located at Part 30-00-1 of this Title; For members of these populations deemed eligible due to a characteristic (newborns) or by current or past participation in a federal or State program (SSI or RI Department of Children, Youth and Families (DCYF)) are set forth in Part 30-00-1 of this Title.

b. Integrate Health Care Coverage (IHCC) Groups and Non-MAGI eligible adults and elders - Information related to non-financial eligibility requirements for all coverage groups subject to determinations using the SSI methodology, including the SSI and Community Medicaid eligibility pathway and Medicare Premium Payment Program (MPPP) are set forth in the application provisions in Part 40-00-1 of this Title and general eligibility section of Part 40-05-1 of this Title.

c. LTSS - All new applicants for LTSS must meet the general eligibility requirements related to age, SSN and residency. Existing Medicaid beneficiaries who are seeking LTSS do not have to provide additional information about these non-financial factors if already known to the State and, therefore, are not subject to verification. For applicants pursing the ACA adult MAGI pathway, the non-financial eligibility requirements are set forth in Part 30-00-1 of this Title. For all other LTSS applicants, the provisions related to the SSI methodology for Community Medicaid located in Part 40-05-1 of this Title apply.

2. State responsibilities -- The State must provide assistance upon request to help applicants obtain and verify information about non-financial eligibility factors. Such information must be accessible to persons with limited English proficiency as well as persons with disabilities. The State's responsibilities related to application information and verification include, but are not limited to:

a. Information for applicants/beneficiaries. The State must inform applicants in both on-line and paper application forms whether attestations related to non-financial eligibility factors are verified, by what means, and how the information will be used in accordance with the applicable provisions of this Title. In addition, when a discrepancy is noted between a data source and an attestation, the State must provide any assistance requested by the applicant to validate and/or correct the information from the data source.

b. Information from applicants. An applicant is only required to provide the information necessary to determine eligibility. In addition, the following limits apply:

(1) Any information requested by the State about non-applicants in the household must be related to the applicant's eligibility. Therefore, information pertaining to a non-applicant's tax filing status, relationship, or income is requested when constructing a MAGI household. Information about the income and resources of a non-applicant spouse is generally required to determine Medicaid eligibility for most of the Integrated Health Care Coverage Group members (request, income, and resources may be required for some types of eligibility).

(2) Request for the SSN of a non-applicant is permitted only if the State indicates clearly that it is being provided voluntarily and for purposes directly connected to initial or continuing eligibility for Medicaid. A non-applicant requesting eligibility for someone else in the household is not required to provide an SSN.

(3) The State does not request information about the citizenship and immigration status of non-applicants in the household.

3.7 Citizenship and Immigration Status

A. The requirements related to citizenship and immigration eligibility factors for Medicaid and CHIP-funded coverage categories are established in federal law as follows:

1. Citizenship -- The federal Deficit Reduction Act (DRA) of 2005 (42 U.S.C. § 1305; 42 U.S.C. § 1396r) requires states to provide Medicaid coverage to otherwise eligible applicants who are citizens and nationals of the United States when appropriate verification of self-attestations is provided.

2. Non-citizens - In accordance with the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, 42 U.S.C. § 1305) and the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (42 U.S.C. § 1396), the following non-citizens are provided with Medicaid or CHIP-funded coverage when all other eligibility requirements are met:

a. Adults. Qualified non-citizens over age nineteen (19) as defined in PRWORA eligible under the Medicaid State Plan --

(1) Prior Entry -- Qualified non-citizens who entered the United States before August 1, 1996;

(2) Exempt from five-year bar -- Qualified non-citizens who are exempt from the five-year bar on Medicaid coverage under federal

law at § 402(b) of PRWORA (8 U.S.C. § 1612(b)), including non-citizens with the following statuses:

> (AA) Refugees. Admitted under Section 207 of Immigration and Naturalization Act (INA) including Afghan and Iraqi Special Immigrants (SIV's) as permitted under Pub. Law 111-118;
>
> (BB) Asylees. Granted Asylum under Section 208 of INA;
>
> (CC) Deportation withheld under 243(h) of INA;
>
> (DD) Amerasian entrants. Pursuant to Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988 (as contained in Section 101(e) of Pub. Law 100-202 and amended by the 9th provision under Migration and Refugee Assistance in Title II of the Foreign Operations, Export Financing and Related Programs Appropriations Act, 1988, Pub. Law 100-461 as amended);
>
> (EE) Cuban or Haitian entrants. As defined in Section 501(e) of the Refugee Education Assistance Act of 1980;
>
> (FF) U.S. Military. Lawfully residing and honorably discharged veterans (except one discharged for reasons of immigration status), or on active duty in the U.S. Armed forces, and their lawfully residing spouses and unmarried dependent children, and the un-remarried widow or widower of the veteran;
>
> (GG) Battered non-citizens. Certain battered spouses, battered children or parents, or children of a battered person with a petition approved or pending under Section 204(a)(1)(A) or (B) or Section 244(a)(3) of INA;
>
> (HH) American Indians. Born outside the U.S. in Canada and is at least fifty percent 50% American Indian blood and to whom the provisions of Section 289 of the INA apply; or is a member of a federally recognized tribe as defined in Section 4(e) of the Indian Self- Determination and Education Act;
>
> (II) Victims of trafficking. Certified by the U.S. Department of Human Services (HHS) Office of Refugee Resettlement pursuant to Section 107(b) of the Victims of

Trafficking and Violence Protection Act of 2000, as a victim of a severe form of trafficking;

(JJ) Receiving disability assistance. Legally entered the U.S. on or after 8/22/96 and received disability related benefits for a condition that is a disability or is pending a disability determination in accordance with 42 U.S.C. § 1381.

(KK) SSI recipients. Receiving benefits for the U.S. Supplemental Security Income (SSI) program. Treated as a qualified exempt non-citizen under provisions of Pub. Law 105-306, if SSI benefits, and associated Title XIX Medicaid were continued and was lawfully residing in the U.S. and receiving SSI on 8/22/96.

(3) After the five-year bar -- Qualified non-citizens who were subject to the five-year bar (waiting period) on Medicaid eligibility AFTER the five-year period is complete, including:

(AA) Lawful permanent residents (LPRs) Green card holders;

(BB) Parolees. Granted parole for at least one (1) year under 212(d)(5) of the Immigration and Nationality Act (INA), except when paroled for prosecution, deferred inspection, or pending removal proceedings;

(CC) Conditional entrants. Granted conditional entry under 203(a)(7) of immigration law in effect before April 1, 1980.

b. Children and youth. As authorized under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, 42 U.S.C. § 1396) and as described in 8 C.F.R. § 103.12(a)(4) the following non-citizen children and youth are NOT subject to the five (5) year bar regardless of date of entry in the U.S.

(1) Qualified Non-citizens - The full range of qualified non-citizens set forth in subpart (a) above and legal non-immigrants whose admission to the United States is not conditioned on having a permanent residence in a foreign country (such immigrants include citizens of the Compact of Free Association States who are considered permanent nonimmigrants but does not include visitors for business or pleasure or students).

(2) Legally Residing Non-Citizens -

(AA) Temporary resident status. Pursuant to Section 210 or 245A of the Immigration and Nationality Act (INA) 8 U.S.C. §§ 1101-1178;

(BB) Temporary protected status. Pursuant to section 244 of the INA (8 C.F.R. § 244);

(CC) Cuban-Haitian entrants. As defined in section 202(b) Pub. Law 99-603 (8 U.S.C. § 1152), as amended;

(DD) Family unity. Pursuant to section 301 of Pub. Law 101-649 (8 U.S.C. § 1151), as amended, as well as pursuant to section 1504 of Pub. Law 106-554 (8 C.F.R. § 245a);

(EE) Deferred enforced departure (DED). In accordance with a decision made by the President;

(FF) Deferred action status. As set forth in INA Service Operations Instructions at OI 242.1(a)(22);

(GG) Adjusted status. The spouse or child of a United States citizen whose visa petition has been approved and who have a pending application for adjustment of status.

(3) INA Non-citizens -- The following categories of non-immigrant children under 101(a)(15) of the Immigration and Nationality Act (INA) (8 U.S.C. § 1101) are also eligible for coverage under Title XXI:

(AA) Immediate family. Parents or children of individuals with special immigration status under section 101(a)(27) of the INA as permitted under section 101(a)(15)(N) of the INA (8 U.S.C. § 1101);

(BB) Fiance(ee) of a citizen as permitted under section 101(a)(15)(K) of the INA (8 U.S.C. § 1101);

(CC) Religious workers under section 101(a)(15)(R) (8 U.S.C. § 1101);

(DD) U.S. Attorney General's discretion. The Attorney General of the United States has determined the non-citizen is in possession of critical reliable information concerning a criminal or terrorist organization, enterprise or operation as permitted under section 101(a)(15)(S) of the INA (8 U.S.C. § 1101);

(EE) Victims of trafficking. As permitted under section 101(a)(15)(T) of the INA (8 U.S.C. § 1101);

(FF) U.S. Department of Justice. When assisting in a criminal investigation as permitted under section 101(a)(15)(U) of the INA (8 U.S.C. § 1101);

(GG) Battered non-citizens;

(HH) Petition pending. A petition pending for three (3) years or more as permitted under section 101(a)(15)(V) of the INA (8 U.S.C. § 1101).

c. Pregnant women. All pregnant women who otherwise meet the requirements for Medicaid are eligible without regard to immigration status.

3. Non-qualified non-citizens - In accordance with the provisions of PRWORA, non-citizens who are not pregnant and do not have current documentation of a qualified non-citizen status are not eligible for Medicaid or CHIP coverage except in instances of a medical emergency. The provisions governing Medicaid coverage for non-citizens who are RI residents in emergency circumstances are set forth in Part 40-05-1 of this Title.

4. Alternative forms of coverage - Lawfully present qualified non-citizens who are ineligible for Medicaid/CHIP funded coverage, may qualify for commercial health insurance coverage through the State's health insurance marketplace known as HealthSource RI (HSRI). To facilitate access to affordable health coverage, any non-citizen who applies for Medicaid and is denied on the basis of immigration status is automatically evaluated for an HSRI plan and is informed if such coverage options are available in the eligibility determination notice.

B. The State verifies self-attestations and attestations of citizenship and satisfactory immigration status through designated electronic federal and State data sources through the IES to the full extent feasible.

1. Exemptions -- The provisions set forth in this Part related to citizenship and immigration status do not apply to the following exempt persons/coverage groups:

a. Persons eligible on the basis of the current or past receipt of Supplemental Security Income (SSI) as specified under Part 40-05-1 of this Title.

b. Anyone entitled to or enrolled in any part of Medicare, including applicants for the Medicaid Premium Payment Program (MPPP) pursuant to Part 40-05-1 of this Title.

c. Recipients of Social Security Disability Insurance (SSDI) and/or federally authorized and funded rehabilitative services, administered through the RI Department of Human Services (DHS) or the RI Office of Rehabilitative Services (ORS) seeking any type of Medicaid coverage;

d. Children and youth, up to age twenty-one (21), who are in the care and custody of the RI Department of Children, Youth and Families (DCYF) and/or participating in foster care and adoption subsidy assistance and maintenance programs and former foster care youth eligible under the federal Chafee Independent Act pursuant to Part 30-00-1 of this Title;

e. Newborns deemed eligible for Medicaid or CHIP in accordance with Part 30-00-1 of this Title.

2. Citizenship - An applicant has met the Medicaid citizenship eligibility requirement when the applicant is an adult and has made a self-attestation of United States citizenship, or the applicant is a minor or incapacitated person and an adult living in the same household or an authorized representative has made a declaration of citizenship on the behalf of the minor or incapacitated person; and the declaration has been verified by an authorized electronic data source.

3. Immigration status - An applicant has met the Medicaid/CHIP immigration status requirement when the applicant has made a self-attestation of satisfactory immigration status; or an attestation of such status has been made on the applicant's behalf by an adult living in the same household or an authorized representative in instances in which the applicant is a minor or incapacitated. An attestation of immigration status may also be accepted when provided by a responsible person with first-hand knowledge of the immigration status of the applicant, but only if the attestation is verified by an authorized electronic data source or approved form of documentation. Special provisions apply in certain circumstance as follows:

a. Veterans. For purposes of determining whether the exemption from the five-year bar for qualified non-citizen veterans and their families applies, the State must verify that the veteran is in honorably discharged or active military duty status, or is the spouse or unmarried dependent child of such person. If the State is unable to verify this information through electronic means, self-attestation with paper documentation providing proof of the veteran's status and/or relationship to the veteran is accepted.

b. Participants in other federal means-tested programs - The State does not re-verify the citizenship or immigration status of an applicant for Medicaid/CHIP funded coverage who is currently participating in a state administered means-tested federal program, providing verification of citizenship and immigration status is a condition of eligibility, has been successfully completed, and record of such is maintained and can be accessed through the IES.

4. Verification sources -- The primary electronic data sources for verifying citizenship and immigration status used by the State is the federal State Verification and Exchange System (SVES) which operates through the Verify Lawful Presence (VLP) interface with the federal data hub (MACC group members subject to MAGI determinations); and, an electronic data exchange with the U.S. Citizenship and Immigration Services (USCIS). As indicated in § 3.7(C) of this Part below, if verification through these sources does not succeed, the State may use alternative electronic or paper forms of verification.

5. Record of verification - The State maintains a record of having verified citizenship and immigration status for each applicant in the IES in accordance with the requirements in 42 C.F.R. § 431.17(c).

6. Agency assistance -- A state agency eligibility specialist is available to provide assistance to an applicant who is unable to provide a declaration or attestation, correct errors or inconsistences, or obtain any required documents as a result of a disability, homelessness, and/or the absence of someone who can act as authorized representative on his/her behalf.

7. Authorized representative -- An authorized representative may submit proof of citizenship, identity and/or satisfactory immigration status on the behalf of an application or beneficiary.

8. Limits - Verification of citizenship and satisfactory immigration status occurs at the point of initial application. Unless an applicant/beneficiary reports a change in citizenship or immigration status, or the State receives information indicating such a change has or may occur, the State may not initiate or require re-verification of either eligibility factor at the point of annual renewal, on a quarterly basis as part of the post-eligibility verification (PEV) process set forth in Part 30-00-5 of this Title, or subsequent to a break in coverage.

3.7.1 Prompt Resolution and Reasonable Opportunity

A. Verification of citizenship and/or immigration status through primary electronic data sources and interfaces may not succeed. In such instances, the verification process proceeds as follows:

1. Prompt resolution -- It is the State's responsibility to promptly attempt to resolve any inconsistencies issues, including typographical or other clerical errors, between information provided by the applicant and information from a primary electronic data source, and resubmit corrected information through such electronic services or an alternative electronic mechanism.

2. Reasonable Opportunity -- If prompt resolution fails to provide verification within five (5) working days, the State provides a reasonable opportunity period. During the reasonable opportunity period, the State continues efforts to complete

verification of the citizenship and/or satisfactory immigration status, or request documentation if necessary.

a. Notice. The State must provide notice to an applicant indicating that a reasonable opportunity period is being initiated. The period begins on the date the notice is received by the applicant which is presumed to be five (5) days after the date on the notice. The notice provides the applicant with the following:

(1) Temporary, provisional eligibility - A statement indicating that a reasonable opportunity period has been initiated. During this period, temporary, provisional Medicaid eligibility is provided to applicants in the household for whom verification is pending for up to ninety (90) days. Temporary, provisional eligibility begins on the first day of the month in which the application was filed and ends when verification is completed, the applicant fails to cooperate or cannot provide any requested verification, or the reasonable opportunity period expires, whichever comes first.

(2) Alternative forms of proof - An additional documentation request (ADR) is included in the notice. The ADR identifies the outstanding verification issues (discrepancy, error, missing data); indicates the corrective action required and how to obtain assistance from the state agency, if appropriate; and provides a list of alternative accepted forms of verification, including paper documentation.

b. Additional State responsibilities - During the reasonable opportunity period:

(1) No limits on coverage -- The State may not delay, deny, reduce or terminate coverage for a person who has been determined otherwise eligible for Medicaid during the reasonable opportunity period, in accordance with 42 C.F.R. § 435.911(c).

(2) Extensions - The State may extend the reasonable opportunity period in instances in which the applicant is making a good faith effort to obtain any necessary documentation or the State needs more time to verify status through other available electronic data sources or to assist an applicant in obtaining documents needed to verify his or her status.

(3) End of eligibility - At least thirty (30) days prior to the termination of the period of temporary, provisional eligibility, the State provides an adverse action notice containing the reason for the terminating eligibility and denying the application for

Medicaid. The notice must contain the right to appeal the eligibility determination decision.

c. Applicant's responsibilities. An applicant must respond to the notice ADR in no more than thirty (30) days plus an additional five (5) days to cover mailing time - a total of thirty-five (35) days. An applicant may show good cause for failing to respond, by providing proof of mail delays or an emergency situation and request an extension of the reasonable opportunity period. An applicant also has the right to appeal and request a hearing. Reapplication is required.

3.8 Sponsor Deeming

A. Under the deeming provisions for non-citizens, the income and resources of the sponsor(s) are counted as available and received, even if not in fact received, by the applicant. Income and resources of the sponsor(s) and of the sponsor's spouse (when living together) are counted when determining the income and resources of the non-citizen applicant.

1. Scope and application -- Deeming applies ONLY to lawful permanent residents (LPR) who:

a. Entered the U.S. or were granted LPR status on or after 12/19/97; and

b. Were sponsored by a person or entity with U.S. citizenship status such a family member, employer, or representative of an academic institution or business owner; and

c. Received legally binding affidavit(s) of support from the sponsor (USCIS form 1-864).

2. Eligibility duration -- Deeming continues until the non-citizen:

a. Attains U.S. citizenship; or

b. Can be credited with forty (40) quarters of work as defined under Title II of the Social Security Act, provided that no credit is given for any quarter after 12/31/96 in which any federal means tested benefit was received. Federal means tested benefits include, but are not limited to: Supplemental Nutrition Assistance Program (SNAP), RI Works, Child Care Assistance Program (CCAP), Supplemental Security Income (SSI) and Low-income Heating Assistance Program (LIHEAP).

(1) Non-citizens may be credited with quarters from their own employment, their spouse's employment, and their parent's employment.

(2) Verification of qualifying quarters must be obtained from Social Security Administration records. A written statement, signed by the applicant under penalty of perjury, may be used as temporary verification of quarters worked while awaiting information requested from Social Security.

B. Deeming provisions may be waived for a period of one (1) year in certain circumstances for sponsored immigrants.

1. Battery or cruelty -- Deeming requirements may be waived when a non-citizen demonstrates that he or she or a child or dependent have been battered or subjected to extreme cruelty while in the U.S. by certain persons who were living in the same household.

a. The battery must have a substantial connection to the need for Medicaid benefits such as to enable the non-citizen and any children/dependents to:

(1) Become self-sufficient following separation from the abuser;

(2) Escape the abuser or the community where the abuser lives, or to gain protection from the abuser;

(3) Obtain health coverage due to a loss of income or a period of health insurance ineligibility suffered as a result of separation from the abuser;

(4) Address health care issues or disabilities resulting from the abuse;

b. In the absence of such a connection to Medicaid, the non-citizen may show that he or she does not have sufficient income or resources for food or shelter without the abuser's financial support and, therefore, may be considered indigent.

(1) To be considered indigent, the sum of the all income including any cash or in-kind assistance must be at or below 130 percent of the FPL.

(2) When determining whether a person is indigent, only the total amount of income and resources actually deemed to the non-citizen during a twelve (12) month period is counted. This is also the amount used when determining Medicaid eligibility for the non-citizen and any children and dependents.

c. The State is required under federal law to notify the USCIS with the name of the sponsor and the sponsored non-citizens receiving Medicaid under this Part. The sponsor must reimburse the State for any Medicaid

payments paid for covered services during a waiver period, with the exception of payments for emergency services.

d. A waiver related to abuse may be renewed if the non-citizen demonstrates the battery or cruelty has been recognized in the order of a judge or administrative law judge or a prior determination of the USCIS and the need for benefits remains the same; or the non-citizen requests a continuation of the waiver based on the indigent standard set forth in § 3.8(B)(1)(b) of this Part above.

e. Accepted forms of proof of battery or cruelty at the time of the initial application for a waiver and, as appropriate, continuation of the waiver include, but are not limited to:

(1) An approved USCIS petition;

(2) Restraining order;

(3) Third party affidavit,

(4) Signed affidavit from the applicant, or

(5) Health care, or public or private agency records.

2. Emergency services -- Deeming provisions do not apply to eligibility determinations for emergency services.

3.9 Evidence Accepted for Verification Purposes

A. Accepted forms of documented evidence for each non-financial eligibility factor is set forth below:

1. Identity -- The State accepts the following as proof of identity, provided such document has a photograph or other identifying information sufficient to establish identity, including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

a. Driver's license issued by a state or territory;

b. School identification card;

c. U.S. military card or draft record;

d. Identification card issued by the federal, state, or local government;

e. Military dependent's identification card;

f. U.S. Coast Guard Merchant Mariner card;

g. For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records;

h. Two (2) other documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards; high school, high school equivalency and college diplomas; marriage certificates; divorce decrees; and property deeds or titles.

i. Finding of identity from a federal or state governmental agency. The State may accept as proof of identity a finding of identity from a another government agency, federal or state, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the identity of the applicant has been verified and certified.

j. If the applicant does not have any of the documentation cited herein, the State accepts an affidavit signed, under penalty of perjury, by a person other than the applicant who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity. The affidavit does not have to be notarized.

2. Social Security Number - The following are accepted forms of proof of Social Security Number:

a. Social Security Card

b. Social Security Records

c. Tax return or other document showing SSN and identity.

3. Date of Birth/Age --In addition to a birth certificate, the State accepts the following evidence of date of birth:

U.S. Passport	Naturalization Certificate
Hospital Birth Records	Social Security Administration Award Letter if DOB is included
Adoption Records	Affidavit of a Third Party
School Records	Military Service Records
Physician Records	USCIS Immigration Documents
Driver’s License or State-issued Photo ID	Church Records (Baptismal Certificate, Confirmation Papers, Marriage Certificate)

Social Security Card or Records	Voter Registration Card
Life Insurance Policy	Family Bible
Marriage License	State/Federal Census Record

4. Citizenship - The evidence accepted as proof of citizenship varies in accordance with the following:

a. Stand-alone evidence of citizenship. The State accepts the following as sufficient evidence of citizenship:

(1) A U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or Card was issued without limitation;

(2) A Certificate of Naturalization;

(3) A Certificate of U.S. Citizenship;

(4) A valid State-issued driver's license if the State issuing the license requires proof of U.S. citizenship, or obtains and verifies a SSN from the applicant who is a citizen before issuing such license;

(5) Documentary evidence issued by a federally recognized Indian Tribe identified in the Federal Register by the Bureau of Indian Affairs within the U.S. Department of the Interior, and including Tribes located in a State that has an international border, which identifies tribe that issued the document; the applicant by name; and; confirms the applicant’s membership, enrollment, or affiliation with the Tribe;

(6) A data match with the Social Security Administration.

b. Secondary evidence - If primary evidence of citizenship is unavailable, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in § 3.10(A)(3) of this Part:

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Guam, American Samoa, Swain's Island, Puerto Rico (if born on or after January 13, 1941), the Virgin Islands of the U.S. or the CNMI (if born after November 4, 1986, (CNMI local time). The birth record document may be issued by a State, Commonwealth, Territory, or local jurisdiction. If the document shows the application was born in Puerto Rico or

the Northern Mariana Islands before the applicable date referenced in this paragraph, the applicant may be a collectively naturalized citizen. In such instances, the State accepts the evidence identified in 42 C.F.R. § 435.945;

(2) At State option, a cross match with a State vital statistics agency documenting a record of birth;

(3) A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S;

(4) A Report of Birth Abroad of a U.S. Citizen;

(5) A Certification of birth in the United States;

(6) A U.S. Citizen I.D. card;

(7) A Northern Marianas Identification Card issued by the U.S. Department of Homeland Security (or predecessor agency);

(8) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a Statement from a State-approved adoption agency that shows the child's name and U.S. place of birth;

(9) Evidence of U.S. Civil Service employment before June 1, 1976;

(10) U.S. Military Record showing a U.S. place of birth;

(11) A data match with the SAVE Program or any other process established by USCIS to verify that an applicant is a citizen;

(12) Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000 as amended (8 U.S.C. § 1431);

(13) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth;

(14) Life, health, or other insurance record that indicates a U.S. place of birth;

(15) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.;

(16) School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth;

(17) Federal or state census record showing U.S. citizenship or a U.S. place of birth;

(18) If the applicant does not have one of the documents listed in §§ 3.9(A)(4)(b)(1) through (17) of this Part herein, he or she may submit an affidavit signed by another person under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

c. Verification of citizenship by a federal agency or another state. The state may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a federal agency or another state, if such verification was done on or after July 1, 2006.

5. Satisfactory Immigration Status - In the event that electronic data sources fail, the State may require an applicant to provide the appropriate form of evidence to prove status, as listed below:

Immigration Status
Birth Certificate (if born in the U.S.) - otherwise this does not show immigration status in the U.S.
U.S. Passport
Naturalization Certificate
Military Service Records
Alien Resident Card (I-155) (also known as a “Green Card”)
Employment Authorization Card (I-688B)
For recent arrivals, a temporary I-551 stamp in a foreign passport or on USCIS Form I-94
Unexpired Re-entry Permit (Form I-327)
Forms AR-3 and AR-3a, Alien Registration Receipt Card
USCIS Form I-94 with stamp showing admission under 203(a)(7) of the INA, refugee-conditional entry
USCIS Form I-688B (or USCIS employment authorization card) annotated 274a.12(a)(3);

Immigration Status
USCIS Form I-766 annotated A3. For lawful permanent residents who are victims of domestic violence - IRS form I551 or I551B coded IB1 through IB3, IB6 through IB8, B11, B12, B16, B17, B20 through B29, B31 through B33, B36 through B38, BX1 through BX3, BX6, BX7 or BX 8 For victims of domestic violence petitioning for legal status who are considered as "qualified aliens" under PROWORA - IRS Form 797 showing an approved 1-360 or 1-13 self-petitioning as a spouse or child of a U.S. citizen or lawful permanent resident; OR USCIS Form 797 showing a Notice of Prima Facie Determination USCIS Form I-94 with date of admission and annotated with unexpired status as listed in Section 0304.05.45.05 Dated USCIS letter or court order indicating a lawfully residing status listed in Section 0304.05.45.05 An unexpired USCIS employment authorization document (I-688-B) annotated with status code Applicants for asylum: I-94, I-589 on file, I-688B coded 274a.12(c)(8) Applicants for suspension of deportation: I-94, I-256A on file, I-688B coded 274a.12(c)(10) Non-citizens granted stays of deportation by court order statute or regulation or by individual determination of USCIS whose departure the USCIS does not contemplate enforcing: letter or Granted a stay of deportation, I-688B coded 274.12(c)(12) Non-citizens granted suspension of deportation pursuant to Section 244 of INA (8 U.S.C. § 1254) whose departure the USCIS does not contemplate enforcing: letter/order from the immigration judge and a Form I-94 showing suspension of deportation granted Non-citizens residing in the United States pursuant to an Order of Supervision: USCIS Form I-220B, I-688B coded 274a.12(c)(18) Temporary Protected Status: I-94 "Temporary Protected Status" and/or I-688B employment authorization coded 274a.12(a)(12) Deferred Enforced Departure: Letter from USCIS; I-688B coded 274a.12(a)(11) Family Unity: USCIS approval notice, I-797, and/or I-688B coded 274a.13 Non-citizens granted deferred action status: Letter indicating that the non-citizen's departure has been deferred and/or I-688B coded 274a.12(c)(14)

Immigration Status
Non-citizens who have filed applications for adjustment of status whose departure the USCIS does not contemplate enforcing: Form I-94 or I-181 or passport stamped with either of the following: "adjustment application" or "employment authorized during status as adjustment applicant"; and/or I-688B coded 274a.12(c)(9)
USCIS Form I-94 annotated with stamp showing entry as a refugee under Section 207 of the INA and date of entry
USCIS Form I-688B (or USCIS Employment Authorization Card) annotated 274a.12(a)(3)
USCIS Form I-766 annotated A3
USCIS Form I-571
USCIS Form 551 (Resident Alien Card) coded RE-6, RE-7, RE-8, or RE-9
USCIS Form I-94 annotated with stamp showing a grant of asylum
Grant letter from the Asylum Office of the USCIS
USCIS Form I-688B annotated with 274a.12(a)(S)
USCIS Form I-766 annotated
Order from Immigration Judge granting asylum
Order from an Immigration Judge showing the date of a grant of deportation withheld under Section 243(h) of the INA
USCIS Form I-688B (or USCIS employment authorization card) annotated 274a.12(a)(10)
USCIS Form I-766 annotated A10
USCIS Form 551 with codes CU6, CU7, or CH6
Unexpired temporary I-551 stamp in a foreign passport or USCIS Form I-94 with codes CU6 or CU7
USCIS Form I-94 with stamp showing the individual paroled as a Cuban/Haitian Entrant under Section 212(d)(5) of the INA
An USCIS Form I-94 annotated with a stamp showing grant of parole under 212(d)(5) of the INA and a date showing granting of parole for at least one (1) year is acceptable verification of this status

Immigration Status
ORS issues a certification letter to adults and a letter of benefit eligibility pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000 to children under eighteen (18) years of age: For adult, the ORS certification letter is proof of qualified non-citizen status; For children under age eighteen (18), the ORS letter of benefit eligibility is proof of qualified non-citizen status.

B. The State accepts a photocopy, facsimile, scanned or other copy of a document that must be accepted to the same extent as an original document identified as accepted evidence under this Part, unless information on the copy submitted is inconsistent with other information available to the State or the State otherwise has reason to question the validity of, or the information in, the document.

3.10 Cooperation Requirements

A. As a condition of eligibility, all Medicaid applicants and beneficiaries must meet certain cooperation requirements which enable to State to meet federal laws, rules and regulations related to obtaining and retaining federal matching funds for the program.

1. General cooperation requirements - Applicants and beneficiaries must:

a. Application information. Provide any information requested by the State that is necessary to determine eligibility for Medicaid;

b. Assignment of rights. Medical support or other third-party payments for health care services must be assigned to the State. An applicant must also assign to the EOHHS any third-party payments for any other household members eligible under the Medicaid and CHIP State Plan and/or Section 1115 demonstration waiver for whom he or she has the legal authority under State law to make such an assignment. This assignment obligation takes effect under State law upon an applicant's filing for Medicaid;

c. Child support. Cooperate in establishing paternity and obtaining support, except when an exemption exists, with the State's Office of Child Care Enforcement. Exemptions exist for pregnant women with no other children until the birth of the child, parent/caretakers in child-only application cases, and children in general. The State does not deny initial eligibility to an adult applying for Medicaid pending cooperation with the child support requirement. However, termination of eligibility is initiated if an adult applicant or beneficiary does not cooperate by the time of the first periodic electronic verification;

d. Enrollment in RIte Share. An applicant with access to cost-effective employer-sponsored insurance (ESI) must enroll in the plan as a condition of eligibility. Medicaid-eligible children are not denied eligibility or subject to the loss of coverage, if their parent/caretakers with access to coverage do not cooperate and enroll in the approved plan. Specific

provisions governing the RIte Share program are located in Part 30-05-3 of this Title;

e. Alternative sources of support and assistance. Take all reasonable actions to make income/resources available to meet needs. A reasonable action is one that will likely result in more financial benefit accruing to a household than the cost of Medicaid coverage. In addition, for eligibility to continue to exist, a beneficiary who claimed that income or resources owned by or owed to him or her are unavailable must show a good faith effort to continue to take reasonable actions unless the State approves a good cause exemption made in writing. Reasonable actions include, but are not limited to:

(1) Filing applications for other benefits to which an applicant/beneficiary may be entitled including, but not limited to, State and federally funded health care and cash assistance programs and income tax credits and private or public retirement benefits, food assistance, or supplemental insurance;

(2) Making formal requests to other joint owners to sell or otherwise liquidate jointly held property;

(3) Requesting guardians, trustees, and other legally authorized representatives to make resources or income available from estates, trusts, settlements, and other financial instruments;

(4) Retain counsel to petition a court to adjudicate any monetary or property claim which the client may have against any person; and

(5) Report to the State at the time of renewal or more frequently upon request progress being made toward making the resource or income available for use.

f. Quality Assurance. Assist the State by providing full cooperation in any quality assurance and/or program integrity activities.

2. Third-party liability - All applicants and beneficiaries must identify and provide information about third-party payers liable for Medicaid covered services and supports and, as required in § 3.10(A)(1) of this Part above, assign rights to payments. Beyond cooperating in this manner, the State generally pursues third-party liability without further assistance from the beneficiary. However, the State may require a beneficiary to:

a. Appear at a designated State or local office to provide information or evidence relevant to the case;

b. Serve as a witness at a court or other proceeding;

c. Provide information, or attest to lack of information, under penalty of perjury;

d. Pay to the State any support or medical care funds received that are covered by the assignment of rights; and

e. Take any other reasonable steps to assist in establishing paternity and securing medical support and payments and in identifying and providing information to assist the State in pursuing any liable third party.

B. Non-cooperation with any requirement that is a condition of eligibility may result in the denial or termination of Medicaid eligibility for applicants and beneficiaries nineteen (19) years of age or older unless specifically exempt in federal or State laws or the rules and/or regulations established under this Title. Such exemptions are identified, as appropriate, in the Chapters of this Title pertaining to each coverage category as indicated in § 3.6(B)(1) of this Part above.

EOHHS General Provisions

Subchapter 00 - Collections and Payments: Liens and Recovery of Medicaid Payments (formerly Medicaid Code of Administrative Rules, Section # 0312) (210-RICR-10-00-4)

4.1 LEGAL authority

In accordance with federal mandates and R.I. Gen. Laws § 40-8-15, this lien and recovery regulation applies to the estates of recipients, whether categorically or medically needy, fifty-five (55) years of age or older at the time of receipt of Medicaid.

4.2 OVERVIEW

A. A lien shall attach against property, which is included or includable in the decedent's probate estate, regardless of whether or not a probate proceeding has been commenced in a probate court. Such a lien shall only be effective upon proper prior notice and if the lien is recorded in the land evidence records in accordance with R.I. Gen. Laws § 40-8-15.

B. This Part, as it applies to all probate proceeding of a decedent aged fifty-five years (55) or older, shall include voluntary informal probate proceedings and any references to an executor or administrator shall include, without limitation, a voluntary executor or voluntary administrator.

4.3 Definitions

A. As used in this section, the following terms shall be construed as follows:

1. "Estate", with respect to a deceased individual, means all real and personal property and other assets included or includable within the individual's probate estate.

2. "Executive Office of Health and Human Services" or "EOHHS" means the state agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 *et seq*. within the executive branch of state government and serves as the principal agency for the purposes of managing the Departments of Children, Youth, and Families (DCYF); Health (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The EOHHS is designated as the "single state agency," authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

4.4 APPLICATION OF THE LIEN

A. The lien shall apply to the individual's estate which includes all real and personal property and other assets that are included or includable within the individual's probate estate. Consequently, an individual's probate estate may be comprised of liquid assets as well as real property, including any resources remaining at the time of death which were allowable in the individual's Medicaid eligibility determination.

B. Other than as provided in § 4.15 of this Part, a lien cannot attach to assets which are not the subject of a probate estate initiated within the State of Rhode Island, or in any other state in which the individual was a domiciliary. Real or personal property which passes by operation of law, or passes to beneficiaries under a contract, deed, annuity, or other instruments such as trust agreements or insurance policies, or any other property which does not require the initiation of a probate process to convey title or beneficial interests or ownership to others, is excluded from the lien process.

C. The lien shall attach against property of a beneficiary, which is included or includable in the decedent's probate estate, regardless of whether or not a probate proceeding has been commenced in the probate court by EOHHS or by any other party. Provided, however that such lien shall only attach and shall only be effective against the beneficiary's real property included or includable in the beneficiary's probate estate upon proper prior notice and if such lien is recorded in the land evidence records and is in accordance with R.I. Gen. Laws § 40-8-15. Decedents who have received Medicaid are subject to the assignment and subrogation provisions of R.I. Gen. Laws §§ 40-6-9 and 40-6-10.

D. The lien for the recovery of Medicaid expenditures:

1. Does not attach during the beneficiary's lifetime;

2. Does not attach to any real or personal property that is not included or includable in the deceased Medicaid beneficiary's probate estate.

E. The lien for the recovery of Medicaid expenditures:

1. Does cover all periods of receipt of Medicaid from and after age fifty-five (55).

2. The recipient does not have to be receiving Medicaid at the time of death.

3. Does attach at death to all assets included or includable within the individual's probate estate. That is, any and all assets that are subject to Probate or to assets where there is no probate due to the use of the Rhode Island "small estates" statute (R.I. Gen. Laws § 33-24-1 *et seq*.).

4. Does attach to and remain a lien upon the estate property, whether or not the property is transferred, and upon all property acquired by the executor or administrator in substitution therefore while that property remains in his or her hands until the Medicaid is paid, but the lien shall not affect any tangible personal property or intangible personal property after it has passed to a bona fide purchaser for value. If there are questions concerning the passage to a bona fide

purchaser, the case will be referred to the EOHHS Legal Office as referenced in § 4.5 of this Part.

5. Notice of said lien shall be sent to the duly appointed executor or administrator, the decedent's legal representative, if known, or to the decedent's next of kin or heirs at law as stated in the decedent's last application for Medicaid, thirty (30) days prior to filing in the land evidence records. Said notice shall include appeal rights as noted in § 4.11 of this Part.

4.5 REQUIREMENTS FOR TRANSFER/SALE OF PROPERTY

A. Whenever an individual who is receiving Medicaid, transfers an interest in real or personal property on or after July 1, 2012, such individual shall notify the EOHHS within ten (10) days of the transfer:

1. EOHHS Legal Office, Virks Building, 3 West Road, Cranston, RI 02920

B. Such notice shall also be sent to the individual's local office. The notice shall include, at a minimum, the individual's name, social security number or, if different, the EOHHS identification number, the date of transfer and the dollar value, if any, paid or received by the individual who received benefits, and the name of the person and relationship of the person to whom the transfer was made.

C. In the event a Medicaid beneficiary fails to provide the required notice of the transfer to EOHHS and in the event the beneficiary, his/her guardian, conservator or agent under a power of attorney, if applicable, his/her spouse and/or immediate family members knew or should have known that such individual failed to provide such notice and that person(s) receives any distribution of less than fair market value as a result of the transfer, he or she shall be liable to the EOHHS to the extent of the uncompensated value of the transfer, up to the amount of Medicaid benefits paid on behalf of the beneficiary.

D. Moreover, any such individual shall be subject to the provisions of R.I. Gen. Laws § 40-6-15 and any remedy provided by applicable state and federal laws and rules and regulations. Failure to comply with the notice requirements set forth in the section shall not affect the marketability of title to real estate transferred.

4.6 EXCEPTIONS TO THE LIEN

A. A lien shall not apply:

1. For periods of receipt of Medicaid before the beneficiary reached the age of fifty-five (55).

2. If the beneficiary is survived by:

a. A spouse; or

b. A child who is under the age of twenty-one (21); or

c. A child who is blind or permanently and totally disabled as defined in Title XVI (SSI) of the Social Security Act.

B. An individual who is a survivor of the deceased beneficiary, as described above, need not be residing in property of the estate or be a beneficiary of the estate.

C. Receipt of SSI, RSDI or Railroad Retirement (RR) benefits is acceptable evidence of disability. However, if the child is not in receipt of such benefits, the characteristic of disability must be determined by EOHHS.

4.7 REDUCTIONS OF THE LIEN UNDER QLTCIP PROGRAM

A. RI has established a Qualified Long-Term Care Insurance Partnership (QLTCIP) program. This Qualified LTC Insurance Partnership provides:

1. For the disregard of a Medicaid applicant's resources in an amount equal to the benefits paid by their QLTCIP policy as of the time of their application for Medicaid; and

2. For the total amount paid by the individual's QLTCIP policy at the time of death to be disregarded in the determination of the amount to be recovered from a beneficiary's estate.

3. The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination. (There may be continuing QLTCIP policy payments after Medicaid eligibility is established, so if the person later gains assets, he/she may have more protected than he/she had at the time of eligibility).

4. Thus, the total amount paid by the individual's QLTCIP at the time of death is to be disregarded in the determination of the amount to be recovered from a beneficiary's estate.

4.8 CLIENT NOTIFICATION

During application for Medicaid for the individual who is fifty-five (55) or older at the time of application or who will turn fifty-five (55) before renewal, the individual, or his/her representative, must be advised that, under Rhode Island law, receipt of Medicaid may constitute a lien upon his/her estate. Similarly, at renewal for Medicaid for an individual who is fifty-five (55) years of age or older or who will become fifty-five (55) before the next renewal, it must be explained to such individual that the lien is an attachment against the individual's estate, taking effect at death, which allows EOHHS to recover from the individual's estate any Medicaid paid on behalf of the individual from the time s/he became fifty-five (55) years of age (and after the effective date of the law). The exceptions in § 4.6 of this Part relative to certain survivors must be explained to the applicant.

4.9 RECOVERY

A. Based on the information regarding the deceased's resources and the assistance which would by law be recovered, a decision regarding recovery is made by EOHHS.

B. EOHHS Recovery Practices:

1. Upon the filing of a petition for admission to probate of a decedent's will or for administration of a decedent's estate, when the decedent was fifty-five (55) years or older at the time of death, a copy of said petition and a copy of the death certificate shall be sent to the EOHHS:

a. EOHHS Legal Office, Virks Building, 3 West Road, Cranston, RI 02920.

2. The notice requirements of this section are in addition to any notice that may be required pursuant to R.I. Gen. Laws § 33-11-5.1 entitled "Duty to notify known or reasonably ascertainable creditors."

3. If the EOHHS requests additional information, an executor or administrator shall complete and send to EOHHS a form prescribed by that office and shall provide such additional information within thirty (30) days of the request. Petitioners shall maintain documentation evidencing notice to the EOHHS Legal Office and file a copy of this notice with the probate court prior to hearing. In the case of a voluntary probate proceeding, since there is no hearing, a copy of the notice to EOHHS shall be filed with the probate court with the voluntary petition.

4. For estates open on or after July 1, 2012, should a petitioner fail to send a copy of the petition and a copy of the death certificate to the EOHHS Legal Office and a decedent has received Medicaid for which the EOHHS is authorized to recover, no distribution and/or payments, including Administration fees, shall be disbursed. Any person and/or entity that receives a distribution of assets from the decedent's estate shall be liable to the EOHHS to the extent of such distribution.

5. Compliance with the provisions of this section shall be consistent with the requirements set forth in R.I. Gen. Laws § 33-11-5 and the requirements of the affidavit of notice set forth in R.I. Gen. Laws § 33-11-5.2. Nothing in these sections shall limit the EOHHS from recovery, to the extent of the distribution, in accordance with all state and federal laws.

6. EOHHS initiates estate recoveries upon receipt of information (from internal or external sources) relative to the death of a Medicaid beneficiary who was at least fifty-five (55) years of age, and responds to requests from estate representatives to release and/or discharge liens upon payment of reimbursable amounts.

C. EOHHS does not automatically file an encumbrance in the land evidence records.

D. Usually, the recovery process begins with a letter to the next of kin or legal representatives requesting estate asset information. In most cases, there are no assets left after payment of funeral expenses and other preferred debts (R.I. Gen. Laws § 33-12-11) and no recovery is pursued by the EOHHS. If requested, EOHHS will issue a discharge of lien. If there are any assets remaining to pay the EOHHS claim, in whole or in part, EOHHS will request reimbursement by letter which provides an accounting of the Medicaid expenditures. Upon receipt of payment, EOHHS will issue a discharge of lien.

E. If the EOHHS is notified of the pendency of a probate estate either in response to a written notice from the executor/administrator, (see R.I. Gen. Laws § 33-11-5.1 for notice to creditor requirements), the EOHHS Legal Office will file a formal claim in the estate. Land evidence lien notices are not normally filed at this time.

4.10 DISCHARGE OF LIEN

A. EOHHS will issue a discharge of its lien in each of the following situations:

1. Upon payment in full of its claim;

2. Upon payment of its claim in part by payment to EOHHS of all remaining estate assets after allowance for the preferences outlined in R.I. Gen. Laws § 33-12-11 and any court-approved expenses relating to any pre-existing guardianship or conservatorship of the decedent.

a. EOHHS does not "compromise" or reduce its claim except as provided above;

b. EOHHS will require the sale or liquidation of non-liquid assets;

3. Upon determination that §§ 4.10(A)(1) and (2) if this Part above are satisfied and the lien is recorded in the land evidence records.

4.11 DISCHARGE OF INAPPLICABLE RECORDED LIEN

A. EOHHS will issue a discharge of a recorded lien upon a determination by EOHHS that the lien is inapplicable. Inapplicability occurs in the following situations:

1. If there is a statutory exception as found in § 4.6 of this Part; or

2. The decedent was never a beneficiary of Medicaid, was not age fifty-five (55), or was receiving Medicaid but was not "Medically Needy" or "Categorically Needy" during the relevant time periods; or

3. The EOHHS received reimbursement from another third-party source or insurer; or

4. No assets are included or includable in the decedent's probate estate; or

5. There is no required form to request a discharge of an inapplicable lien. A written request for discharge should be sent to:

a. EOHHS, Virks Building, 3 West Road Cranston, RI 02920 and should contain, at a minimum:

(1) A copy of the Death Certificate;

(2) The decedent's Social Security Number;

(3) A detailed explanation of the basis for a finding of inapplicability, with appropriate documentation for the finding. Acceptable documentation may include affidavits;

(4) A description of the real estate (tax assessor's plat/lot numbers and street address).

B. EOHHS will review and verify the information and will compare with information previously disclosed on Medicaid applications on file with the EOHHS. If approved, EOHHS will issue and record a discharge of lien within forty-five (45) days of receipt of the request for discharge due to inapplicability or refer the request to the EOHHS Legal Office, if necessary. Any interested party who disputes the applicability of the land records lien, within thirty (30) days of the proper prior notice as provided in § 4.4 of this Part shall be afforded an opportunity to request an administration hearing (R.I. Gen. Laws § 42-35-9).

4.12 UNDUE HARDSHIP CONSIDERATION

A. EOHHS may make adjustments to and settle estate liens to obtain the fullest amount practicable.

B. A lien may be postponed in whole or in part when EOHHS determines execution of the lien would work an undue hardship.

C. An undue hardship may be found to exist and execution of the lien may be postponed if a sale of real property, in the case of an individual's home, would be required to satisfy a claim, if all of the following conditions are met.

D. An heir or beneficiary may request that the EOHHS delay the execution of its lien if:

1. An individual was using the property as a principal place of residence on the date of the recipient's death; and

2. That individual resided in the decedent's home on a continual basis for at least twenty-four (24) months immediately prior to the date of the deceased recipient's death; and

3. That individual has, from the time EOHHS first presented its claim for recovery against the deceased recipient's estate and after, annual gross income in an amount not to exceed 250 percent (250%) of the then applicable federal poverty level (FPL) income standard based on the same family size, and assets not to exceed the then applicable Medically Needy resource standards.

E. If an individual meets the above criteria, the heir(s) or beneficiary(ies) may submit a request to the EOHHS Legal Office for consideration of undue hardship and the delay of the execution of EOHHS's lien against the property if it appears that the individual is able to continue to reside in the property.

F. Requests for consideration of undue hardship will be reviewed by a team of three members therein designated by the Medicaid Director. The review team will render decisions by giving due consideration to the equities involved as well as the obligations of the parties involved.

G. Additionally, undue hardship will be determined by EOHHS on a case-by-case basis and will include, but will not be limited to, the following:

1. Be rendered homeless without the resources to find suitable housing; or

2. Lose his/her means of livelihood; or

3. Be deprived of food, clothing, shelter, or medical care such that life would be endangered should a finding of undue hardship be denied.

4.13 APPLICATION FOR UNDUE HARDSHIP CONSIDERATION

A. A requestor shall mail his or her application for an undue hardship consideration in writing to EOHHS within forty-five (45) days after the date EOHHS has filed its claim with probate court. The application shall include the following information:

1. The relationship of the undue hardship applicant to the decedent and copies of documents establishing that relationship; and

2. The basis for the application and documentation supporting the undue hardship applicant's position; and

3. Supporting documentation that the requestor has the legal standing and will be allowed to continue to reside in the property indefinitely should the undue hardship request be approved.

B. EOHHS may require additional documentation, such as a current title examination or a list of existing creditors, as adequate proof that its decision to defer its lien will not otherwise adversely affect its claim.

C. EOHHS shall review each application and issue a written decision within ninety (90) days after the application was received by EOHHS. EOHHS shall consider and base its

decision on all information received with the application and any independent investigation it may undertake.

D. The decision shall be the final decision of EOHHS.

4.14 UNDUE HARDSHIP GRANTED

A. If EOHHS finds that an undue hardship exists, the execution of the lien is delayed for as long as:

1. The undue hardship grantee is alive and residing in the property; and has income and assets not to exceed the amounts specified in this Part.

2. The undue hardship circumstances upon which the decision is based continue to exist; and

3. As long as the property is adequately maintained and continues to exist in its then current state.

B. The circumstances of the hardship will be subject to review by EOHHS at least every two years; provided however, that the grantee must notify EOHHS of any material change in circumstances, income and/or assets.

4.15 TRANSFER/SALE OF PROPERTY UNDER HARDSHIP

If the owner of the property sells or transfers ownership of the home, EOHHS will execute the lien.

EOHHS General Provisions

Subchapter 00 - Interception of Insurance Payments (210-RICR-10-00-5)

5.1 Legal Authority

A. Federal law requires the Executive Office of Health and Human Services (EOHHS) to seek recovery of Medicaid expenses from Medicaid beneficiaries' third-party payments. The purpose of this regulation is to set forth the process for the recovery of such payments by the State using the Medical Assistance Intercept System (MAIS) as mandated by R.I. Gen. Laws Chapter 27-57.1.

B. In accordance with R.I. Gen. Laws § 40-6-9 and applicable administrative rules, when applying for Medicaid, an applicant automatically assigns, as a condition of eligibility, his/her rights of subrogation to the EOHHS for any third-party payments from insurers. Nothing in this Part shall limit EOHHS from recovery of any other monies allowed, to the extent of the distribution, in accordance with all state and federal laws.

5.2 Definitions

A. For the purposes of this regulation, the following terms shall be construed as follows:

1. "Executive Office of Health and Human Services" or "EOHHS" means the state agency that is designated under the Medicaid State Plan as the single state agency responsible for the administration of the Title XIX Medicaid Program.

2. "Worker's Compensation" means an insurance program that provides wage replacement and medical benefits to employees injured during the course of their employment in exchange for the mandatory relinquishment of the employee's right to sue the employer.

5.3 Process for Recovery

A. Every domestic insurer or insurance company authorized to issue policies of liability insurance and any worker's compensation insurer or self-insured employer, shall review information provided by the EOHHS, pursuant to R.I. Gen. Laws Chapter 27-57.1, indicating whether or not the claimant has received Medicaid funded services as a result of an accident or loss which is the basis of the claim. Said review shall occur within thirty (30) days prior to making any payment equal to or in excess of five hundred dollars ($500.00) to any claimant who is a resident of this state, for personal injury or Workers'

Compensation benefits under a contract of insurance. For Workers' Compensation insurers, or self-insured employers, said review shall occur within thirty (30) days prior to making any lump sum settlement (R.I. Gen. Laws § 28-33-25), denial and dismissal settlement (R.I. Gen. Laws § 28-33-25.1) or specific compensation (R.I. Gen. Laws § 28-33-19) payment equal to or in excess of five-hundred dollars ($500) to any claimant who is a resident of this state.

B. The EOHHS shall electronically furnish these insurers and insurance companies with a database data match option report of names of individuals with last known addresses, as of the date of the report, who have received Medicaid in excess of five hundred dollars ($500).

C. To facilitate the efficient and prompt reporting of those Medicaid beneficiaries in one centralized location, the duty and responsibility of the insurance companies doing business is as follows:

1. Utilize one centralized database, to which the EOHHS shall report and administer.

2. Any insurer receiving information identifying a Medicaid beneficiary shall maintain the confidentiality of that information to the full extent required under federal and state law. Minimal data elements, including, but not limited to, the date of injury and other necessary identifying information, shall be shared with an agency contracted by the EOHHS which maintains a centralized database of insurance claims.

3. The contracted centralized database is required to keep confidential: any personal and personnel information; records sufficient to identify a person applying for or receiving Medicaid; preliminary drafts, notes, impressions, memoranda, working papers, and work products; as well as any other records, reports, opinions, information, and statements deemed confidential pursuant to state or federal law or regulation, or rule of court. Any such confidential data shall not be disclosed to the insurer except that in the case of Workers' Compensation where the agency shall share that information necessary for the Workers' Compensation insurer or self-insured employer to comply with its obligations pursuant to R.I. Gen. Laws §§ 28-33-5 to 28-33-8.

4. Matched results indicating that a beneficiary is a claimant of an insurer are returned to the EOHHS through its contracted agency. Proper quality assurance shall be performed by the contracted agency to insure the claim is open. The contracted agency may also collect additional information from the insurer, including but not limited to contact information.

D. If the insurer determines from the information provided by the EOHHS, pursuant to R.I. Gen.Laws § 27-57.1-4, that the claimant or payee has received Medicaid funded services, as a result of an accident or loss which is the basis of the claim, the insurer shall, except to the extent that payments are subject to liens or interests (such as, health care providers, attorney fees, holders of security interests, or the assignment of rights under R.I. Gen. Laws §§ 40-6-9 and 40-6-10), withhold from payment the amount to the extent of the distribution for Medicaid as a result of an accident or loss, dating back to the date of the incident. Insurers shall not pay any amount of the settlement to the claimant or claimant's legal representative prior to payment to Medicaid in satisfaction of its lien and shall not accept promises to pay Medicaid and/or hold harmless from any person, firm, or corporation. The insurer shall pay such lien amount to the EOHHS and shall pay the balance to the claimant or other entitled person. Workers' Compensation claimants who receive Medicaid, provided in accordance with R.I. Gen. Laws Chapter 40-8, shall be subject to the provisions of R.I. Gen. Laws Chapter 27-57.1. The Workers' Compensation reimbursement payments made to the EOHHS shall be limited to that set forth in R.I. Gen. Laws Chapter 28-33 and R.I. Gen. Laws § 40-6-10.

5.4 Notice

A. The EOHHS shall provide written notice to the insurer, claimant and his/her attorney, if any, which shall include the date, name, social security number, case number, total amount of the payment proposed to be withheld to reimburse the state for Medicaid funded services and a list of the items and services, including dates of service for which reimbursement is sought. The notice shall explain the right to request a hearing pursuant to § 5.5 of this Part.

B. Claimant's counsel shall have access to the centralized database to update all liens prior to settlement as provided for herein; and to ensure compliance with R.I. Gen. Laws Chapter 27-57.1 and R.I. Gen. Laws §§ 40-6-9 and 40-6-10. Claimants should be aware that the liens under the intercept rules currently apply to "fee-for-service" Medicaid. If a claimant is also covered by a Medicaid Managed Care Organization (MCO), that entity may also have a Medicaid lien.

5.5 Request for Hearing

Any payments made by an insurer pursuant to these rules, shall be made to the EOHHS, unless there is a request for an administrative hearing by the claimant. Any claimant aggrieved by any action taken under these procedures may, within thirty (30) days of the date of the notice to the claimant, request an administrative hearing from the EOHHS. If there is an administrative hearing, the insurer must remit payment within ten (10) business days of and in accordance with the hearing decision.

5.6 Timeline for Payment by Insurer

The insurer shall make any payments required, pursuant to these rules, to the EOHHS, thirty (30) days after the date of notification to the claimant or his/her attorney. Provided, however, that if the claimant has requested a hearing, payment shall not be made until ten (10) days after the hearing decision and in accordance with the hearing decision.

5.7 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.

Chapter 10 – EOHHS General Provisions

Subchapter 00 - Collection of Overpayments via State Tax Refund Offset (formerly Medicaid Code of Administrative Rules, Section #0313) (210-RICR-10-00-6)

6.1 Legal authority

In accordance with R.I. Gen. Laws §§ 44-30.1-1, 44-30.1-3, 44-30.1-4 and 44-30.1-8 entitled, "Setoff of Refund of Personal Income Tax", the Executive Office of Health and Human Services (EOHHS) is authorized to recover Medicaid benefit overpayments and cost share arrearages through the offset of the individual's state income tax refund.

6.2 Definitions

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

1. "Medicaid benefit overpayment" means any amount paid to or on behalf of a Medicaid beneficiary for a Medicaid benefit to which the beneficiary was not entitled, including but not limited to, an overpayment of a RIte Share premium.

2. "Medicaid cost share arrearage" means any amount due and owed to EOHHS as a result of a Medicaid beneficiary's failure to pay their cost share obligation, including any amount due for a cost sharing obligation or Medicaid premium obligation, imposed in accordance with R.I. Gen. Laws Chapter 40-8.4.

6.3 Criteria for Claims Referred for Setoff

A. The Medicaid claim referred for setoff must comply with the State Personal Income Tax Refund Offset procedure (as below).

B. The Medicaid claim must be:

1. Established by court order, by administrative hearing conducted by EOHHS, or by written agreement between the EOHHS and the individual:

a. Greater than or equal to the minimum amount required for submission for setoff by the R.I. Division of Taxation. The Division of Taxation shall, from time to time, determine the minimum amount of claim to which the setoff procedure may be applied.

b. Submitted in the name of one individual or must be reduced by any amount submitted as a separate claim for other individuals who are jointly or severally liable for the claim; and

c. Not involved in a bankruptcy stay or discharged in bankruptcy.

C. In addition, EOHHS must notify the individual of the intended action prior to offset and of her or his appeal rights.

6.4 Setoff Procedures and Notification of Debtor

A. EOHHS will notify the individual of its intent to refer a claim to the R.I. Division of Taxation for offset and provide the individual with thirty (30) days to appeal the intended referral by presenting evidence that all or part of the claim is not legally enforceable. The thirty (30) day notice ("pre-offset notice") shall contain the following information:

1. The amount of the claim(s);

2. That the claim is legally enforceable;

3. The individual's Medicaid Case Identifier;

4. That the claim(s) is to be referred to the R.I. Division of Taxation for offset unless the claim is paid in full within thirty (30) days of the date of the letter;

5. Instructions about how to pay the claim(s), and the address and telephone number to call to discuss the claim and the intended intercept.

6. That the individual has the right to appeal the offset. The notice will advise:

a. That the individual is entitled to an administrative hearing to contest the setoff. The appeal request must be in writing and must be received by EOHHS not later than thirty (30) days after the date of the notice.

b. The general nature of the potential defenses available to the debtor;

c. The rights of non-obligated spouses with respect to income tax refunds in the event a joint return is filed;

d. The individual's right to judicial review of the administrative hearing decision.

B. The notice must also state that a claim may not be referred for offset where a bankruptcy stay is in effect or if the claim has been discharged in bankruptcy.

6.5 Transfer of Funds by the R.I. Division of Taxation

A. At the time of the transfer of funds to EOHHS, the R.I. Division of Taxation shall notify the debtor that the transfer has been made.

B. The notice shall state the name of the debtor, the amount of Medicaid benefit overpayment or cost share arrearage being claimed, the amount of the refund in excess of the amount claimed, if any, and that the transfer of funds to EOHHS was made.

C. In the case of a joint refund, the R.I. Division of Taxation notice shall also state the name of a taxpayer-spouse named in the return, if any, against whom no Medicaid benefit overpayment or cost share arrearage is claimed, the opportunity to request that the refund be divided between the spouses by filing an amended income tax return showing each spouse's share of the tax and the contribution to the overpayment of tax resulting in the refund.

D. Upon receipt of funds transferred from the R.I. Division of Taxation, EOHHS deposits and holds the funds in an escrow account until final determination of setoff. Upon final determination of the amount of the claim to be set-off by:

1. default for failure to apply for an administrative hearing, or by

2. decision of the administrative hearing officer, EOHHS shall remove from the account of the claim payment from the escrow account and credit the amount to the debtor's obligation. The pendency of judicial proceedings to review the administrative decision shall not stay nor delay the setoff, transfer, and disbursement of the tax refund in question.

E. With respect to setoff for Medicaid benefit overpayments and cost share arrearages, the R.I. Division of Taxation shall provide the debtor's address and social security number to EOHHS. The information obtained by EOHHS through the R.I. Division of Taxation retains its confidentiality and is only used by EOHHS in pursuit of its Medicaid benefit overpayments and cost share arrearages collection duties and practices, and any employee or prior employee of EOHHS who unlawfully discloses that information for any other purpose, except as specifically authorized by law, is subject to the penalties specified by R.I. Gen. Laws § 44-30-95(c).

6.6 ADMINISTRATIVE HEARINGS

A. As appropriate, an administrative hearing may be held pursuant to the "Medicaid Code of Administrative Rules, Section #0110, 'Complaints and Appeals'".

B. The hearing officer must issue her or his decision in writing in accordance with the "Medicaid Code of Administrative Rules, Section #0110, 'Complaints and Appeals'". If the decision is made that the claim does not meet the requirements for offset, EOHHS must take appropriate corrective action.

6.7 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.

Chapter 10 – EOHHS General Provisions

Subchapter 05 - Consumer Rights, Responsibilities, and Protections (Confidentiality Rule 210-RICR-10-05-1)

1.1 Purpose

A. The Executive Office of Health and Human Services (EOHHS) has an ethical and legal obligation to safeguard and maintain as confidential the information it receives from or about Medicaid applicants and beneficiaries. In accordance with R.I. Gen. Laws Chapter 40-6, all records pertaining to the administration of the Medicaid Program are confidential in nature. It is unlawful for any person to make use of, or cause to be used, any information contained in these records for purposes not directly connected with the administration of the Medicaid Program, except with the consent of the person affected.

B. Further, 42 C.F.R. § 431.300 *et seq*. requires EOHHS to have safeguards in place that restrict the use or disclosure of information about Medicaid applicants and beneficiaries. The purpose of this document is to meet this requirement and to safeguard and maintain applicant /beneficiary information as confidential.

C. Nothing in this section shall be deemed to prohibit the EOHHS Secretary, or his/her duly authorized agents, from issuing any statistical material or data, or publishing or causing the same to be published whenever he/she shall deem it to be in the public interest.

1.2 Legal Authority

A. These rules are promulgated pursuant to the authority set forth in R.I. Gen. Laws Chapter 40-8 ("Medical Assistance") and various sections in the State's General Laws including: §§ 5-37.3-4-1 *et seq*. ("Confidentiality of Health Care Communications and Information Act"); 23-5-9 ("Upon Death, Reports of Infectious Disease"); Chapter 40-6 ("Public Assistance Act"); §§ 40-6-12 ("Records as to Assistance"); and 42-72-8 ("Confidentiality of Records, Department of Children, Youth, and Families").

B. Additional authority is derived from Title XIX of the Social Security Act; the State's Medicaid State Plan; and the Rhode Island Comprehensive Section 1115 Demonstration, as approved in final form on February 25, 2014, and as subsequently amended.

C. Additional confidentiality provisions exist for Medicaid beneficiaries who are receiving treatment for HIV/AIDS and mental health/substance use. These provisions are contained in State law, in substantive part, as follows: R.I. Gen. Laws §§ 23-1.10-13 ("Confidentiality of records -Availability for Research, Health and Safety"); 23-6.3-7 ("Confidentiality, Prevention and Suppression of Contagious Diseases - HIV/AIDS"); 23-6.3-8 ("Protection of Records, Prevention and Suppression of Contagious Diseases - HIV/AIDS"); 23-28.36-3 ("Notification of Fire Fighters, Police Officers and Emergency Medical Technicians After Exposure to Infectious Diseases"); 40.1-5-5 ("Admission of Patients Generally, Rights of Patients, Patients' Records, Competence of Patients -

Mental Health Law"); and 40.1-5-26 ("Disclosure of Confidential Information and Records, Mental Health Law").

D. Additional federal regulatory requirements related to confidentiality and protection of records are adopted by reference below.

1.3 Incorporated Materials

A. These regulations hereby adopt and incorporate the following 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:

1. 42 U.S.C. § 1396a(a)(7) ("State Plans for Medical Assistance");

2. 42 C.F.R. § 431.300 ("Safeguarding Information on Patients and Beneficiaries");

3. 42 C.F.R. Part 2 ("Confidentiality of Substance Use Disorder Patient Records");

4. 42 C.F.R. § 460.200 (PACE Programs, Maintenance of Records and Reporting of Data");

5. 42 C.F.R. §§ 435.940 through 435.965 ("Verifying Financial Information");

6. 42 C.F.R. § 483.10(h) (Nursing Facilities "Resident Rights, Privacy and Confidentiality");

7. 45 C.F.R. §§ 164.102 through 164.534 ("Security and Privacy").

1.4 Definitions

A. As used herein, the following terms shall be construed as follows:

1. "Confidential" means that information is safeguarded, protected, and shared only on a "need-to-know" basis.

2. "Executive Office of Health and Human Services" or "EOHHS" means the state agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 *et seq*. within the executive branch of state government and serves as the principal agency for the purposes of managing the Departments of Children, Youth, and Families (DCYF); Health (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The EOHHS is designated as the "single state agency," authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

1.5 Confidentiality Criteria

A. The use and disclosure of information concerning Medicaid applicants and beneficiaries shall be limited to purposes directly related to:

1. The administration of the Medicaid Program. This includes, but is not limited to, establishing eligibility, determining the amount of Medicaid benefits provided, and providing services for applicants and beneficiaries.

2. Any investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of the Medicaid Program.

3. The administration of any other federal or state assistance program that provides assistance, in cash or in kind, or services, directly to individuals on the basis of need.

4. Any other release shall be with the beneficiary's written permission, as obtained by EOHHS.

B. The disclosure to any committee or legislative body (federal, state, or local) of any information that identifies, by name and/or address, any applicant or beneficiary is prohibited.

C. The EOHHS Secretary, or his/her designee, may inquire into the records of any state department or agency in the course of his administration of public assistance programs.

1.6 Types of Information to be Maintained as Confidential

A. It is the beneficiary's right and expectation that all information requested about him/her and his/her situation will be respected and safeguarded by EOHHS and all its personnel. The beneficiary will be made aware of his/her right to confidentiality in the application process.

B. The types of information to be safeguarded are as follows:

1. Name and address of applicant or beneficiary;

2. Information related to the social and economic conditions or circumstances of an applicant or beneficiary;

3. Agency evaluation of information about an applicant or beneficiary;

4. Medical data, including diagnosis and history of disease or disability concerning an applicant or beneficiary;

5. Any other material defined in law or regulation as a confidential matter;

6. Any information received for verifying income eligibility and amount of Medicaid payments;

7. Information received from the Social Security Administration or the Internal Revenue Service that must be safeguarded according to the requirements of the agency furnishing the data;

8. Any information received in connection with the identification of legally liable third party resources under the provisions of 42 C.F.R. § 433.138;

9. Any information which, at the discretion of the EOHHS Secretary, or his/her designee, is deemed necessary for the proper administration of the Medicaid Program.

C. General data, not identified with any applicant or beneficiary, such as total expenditures, numbers of beneficiaries, statistical information, and social data contained in general studies, reports, or surveys is not contained in the class of material to be safeguarded and treated as confidential. In the use of case material for research or training, the identity of the beneficiary and his/her family must be protected.

1.7 Procedures to Maintain Confidentiality

A. EOHHS has established the following procedures to safeguard the conditions for use and release of confidential applicant / beneficiary information:

1. Orientation for new staff members and ongoing in-service staff trainings shall include the topic of confidentiality and EOHHS policies and procedures related to its implementation.

2. All newly appointed staff, who will have access to applicant /beneficiary records, must sign a statement attesting to the fact that they have read the State's confidentiality agreement and that they will maintain compliance with same.

3. The applicant's/ beneficiary's right to privacy shall be protected during any necessary interviews. The information to be safeguarded will only be shared with others as is necessary and appropriate for purposes of administering the Medicaid Program.

4. Contractors, vendors, and any other persons having in their possession information related to Medicaid applicants/ beneficiaries must execute data exchange agreements with EOHHS that safeguard the confidential nature of this information.

5. Information must be adequately stored and processed so that it is protected against unauthorized disclosure. All paper records and electronic files shall be properly stored and shall only be available to the staff responsible for the administration and supervision of the Program.

6. Materials sent or distributed to applicants, beneficiaries, or providers of services must be limited to that which are directly related to the administration of the Medicaid Program and have no political implications except to the extent required to implement the National Voter Registration Act (Public Law 103-931). Materials such as "holiday" greetings, public announcements, partisan voting information, and non-citizen registration notices shall not be mailed or distributed.

7. Materials in the immediate interest of the health and welfare of applicants / beneficiaries, such as announcements of free medical examinations, availability of surplus food, and consumer protection information are not prohibited.

8. Only the names of persons directly connected with the administration of the Program shall be contained in material sent or distributed to applicants/ beneficiaries and vendors. Such persons shall only be identified in their EOHHS official capacity.

1.8 Release of Information

A. The release or use of information concerning an applicant or beneficiary applying for or receiving assistance or services is restricted to other social agencies whose representatives are subject to standards of confidentiality that are substantially similar to those of EOHHS.

B. EOHHS must obtain permission from an applicant/beneficiary or their family, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility, or the amount of Medicaid payments.

C. In an emergency, when the applicant/beneficiary cannot be reached to obtain consent, s/he will be notified immediately by EOHHS after the information is supplied.

D. In the event of the issuance of a subpoena for the case record or for any EOHHS representative to testify concerning an applicant or beneficiary, the request must be transmitted to EOHHS Division of Legal Services. The Court will be advised by EOHHS's lawyer of these rules and regulations against disclosure of information. The same policy applies to requests for information from a governmental authority, the courts, a law enforcement official, or the media.

E. EOHHS exchanges information with other entities to verify the income and eligibility of applicants and beneficiaries. Information made available by EOHHS is only to the extent necessary to assist in the valid administrative needs of the program receiving the information. Information received under § 6103(1) of the Internal Revenue Code will be exchanged only with agencies authorized to receive that information under that section of the IRS Code.

1.9 Disclosure of Tax Data

A. Section 26 U.S.C. § 6103(l) of the Internal Revenue Code does not allow for disclosure of tax data by the State except when such disclosure is for the purposes of determining eligibility or the amount of benefits for a public assistance program.

B. The taxpayer does not have authority to authorize the EOHHS to disclose tax data in his/her file.

C. Section 26 U.S.C. § 7213(a) of the Internal Revenue Code prohibits disclosure of any return or return information. Violations of this statute shall be a felony punishable by a fine in any amount not exceeding $5,000, or imprisonment of not more than five (5) years, or both, together with the costs of prosecution.

D. Section 26 U.S.C. § 7431 of the Internal Revenue Code provides that any person who knowingly, or by reason of negligence, discloses any return or return information with respect to a taxpayer, is subject to civil action for damages in a District Court of the United States.

1.10 Access to Public Information

A. EOHHS recognizes both the public's right to access public records and the individual's right to dignity and privacy. It is EOHHS's policy to facilitate public access to all public records that may be disclosed in accordance with R.I. Gen. Laws Chapter 38-2. It is also the policy of EOHHS to ensure all public records under its jurisdiction are available for public inspection and reproduction consistent with all applicable state and/or federal laws, unless otherwise prohibited by a court of competent jurisdiction.

B. EOHHS has established regulations to set forth the specific rules to access public records maintained by EOHHS. (Please refer to "Access to Public Records" regulations).

1.11 Penalties and Sanctions

R.I. Gen. Laws § 40-6-12 states that any person violating any of the provisions of these rules and regulations shall be deemed guilty of a misdemeanor, and shall be fined not more than two hundred dollars ($200) or shall be imprisoned for not more than six (6) months, or both. Other provisions of law cited herein may contain additional penalties and sanctions for violations of confidentiality and/or privacy.

1.12 Severability

If any provision in any section of this rule or the application thereof to any person or circumstances is held invalid, its invalidity does not affect other provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

Chapter 10 - EOHHS General Provisions

Subchapter 05 - Consumer Rights, Responsibilities, and Protections

Appeals Process and Procedures for EOHHS Agencies and Programs (210-RICR-10-05-2)

2.1 Purpose, Scope and Applicability

2.1.1 LEGAL AUTHORITY

A. The Rhode Island Executive Office of Health and Human Services (EOHHS) was established in 2006 within the executive branch of state government and serves as the principal agency of the executive branch for the purposes of managing the Departments of Children, Youth, and Families (DCYF); Health (RIDOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The EOHHS is designated as the "single state agency," authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et. seq*.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

B. Although the four (4) state agencies under EOHHS (DCYF, RIDOH, DHS, and BHDDH) maintain the authority to execute their respective administrative powers and duties in accordance with state law, R.I. Gen. Laws § 42-7.2-6.1(2) transferred to the EOHHS the principal responsibility for "legal services including applying and interpreting the law, oversight of the rule making process, and administrative duties and any related functions and duties deemed necessary by the secretary" for all publicly funded health and human services. It is in this capacity that the EOHHS is authorized and designated by state law to be the entity responsible for appeals and hearings related to the publicly-funded health and human services programs identified in § 2.1.3 of this Part below. EOHHS has been authorized as the designated exchange appeals entity pursuant to the Rules and Regulations Pertaining to HealthSource RI, 220-RICR-90-00-1.

2.1.2 PURPOSE

The purpose of this rule is to set forth the respective roles and responsibilities of the EOHHS and beneficiaries pertaining to the exercise and protection of the right to dispute certain agency actions by filing an appeal to request an administrative fair hearing.

2.1.3 SCOPE AND APPLICABILITY

A. In accordance with R.I. Gen. Laws § 42-7.2-6.1, the provisions of this rule apply to both applicants for and beneficiaries of publicly funded health and human services programs administered by the agencies operating under the

EOHHS umbrella as well as to providers and other interested parties who may be affected by any actions they take.

1. Scope. The EOHHS is authorized by law, regulation, or directive of the Secretary to manage the appeals and hearing process for the agencies under its jurisdiction and such agencies as delegated to EOHHS. The EOHHS is also authorized to act as the appeal entity for transfers and discharges from licensed nursing facilities and assisted living residences for all payers. The rule covers both the appeal and hearing processes. The rule is organized as follows:

a. Section 2.1 – Purpose, Scope, and Applicability. In addition to establishing the legal basis for the rule and its purpose, scope, and application, this part also sets forth the definitions for key terms and processes used throughout the rule.

b. Section 2.2 – Appeals Process. General provisions for the appeals process, including appeal filing requirements and procedures, appellant and agency responsibilities, and informal options for resolving an appeal.

c. Section 2.3 – Administrative Fair Hearings and Appeal Decisions. This section sets forth the provisions governing the administrative fair hearing process and the disposition of appeals.

d. Section 2.4 – Agency/Program Special Provisions. The rule sets forth any agency/program-specific provisions required under applicable federal and/or state laws and regulations. These agency/program specific requirements are noted within the general provisions where applicable unless of such significant scope and effect that it was necessary and appropriate to include them in a separate section of this Part.

2. Applicability. The provisions set forth in this rule apply on a statewide basis to the following agencies and programs:

a. Rhode Island Works (RIWorks) (See Rhode Island Department of Human Services (DHS) Rules and Regulations)

b. Child Care Assistance Program (CCAP) (See DHS Child Care Assistance Program Rules and Regulations, 218-RICR-20-00-4)

c. Supplemental Nutrition Assistance Program (SNAP), formerly “Food Stamps” (See DHS Rules and Regulations, 218-RICR-20-00-1)

d. Supplemental Security Income and State Supplemental Payment Program, (218-RICR-20-00-5)

e. Office of Child Support Services (OCSS) (See Rhode DHS Rules and Regulations, 218-RICR-30-00-1). To the extent the OCSS administers a case in Family court, those matters are not governed by or otherwise subject to this rule.

f. General Public Assistance Program (GPA) (See DHS "General Public Assistance Program Sections 0600-0626 of the DHS Manual")

g. Long-term Ombudsman, Community-Based Services, and Security Housing for the Elderly, Rhode Island Division of Elderly Affairs (DEA) of the DHS, programs and services (R.I. Gen. Laws Chapter 42-66 and DEA Rules, Regulations and Standards Governing the Home and Community Care Services to the Elderly Program (218-RICR-40-00-4); Rules, Regulations, and Standards for Certification of Case Management Agencies (218-RICR-40-00-5); Rules and Regulations Governing the Long Term Care Ombudsperson Program (218-RICR-40-00-1); Rules and Regulations Governing the Prescription Drug Discount Program for the Uninsured (218-RICR-40-00-6); Rules, Regulations, and Standards Governing the Pharmaceutical Assistance to the Elderly Program (218-RICR-40-00-2); and Rules, Regulations, and Standards Governing Security for Housing for the Elderly (218-RICR-40-00-3)

h. Vocational Rehabilitation (VR) Program and Services for the Blind and Visually Impaired Program (SBVI), Office of Rehabilitation Services' (ORS) of the Department of Human Services (See DHS "Vocational Rehabilitation Program Regulations," (218-RICR-50-00-1); "Services for the Blind and Visually Impaired – Social Service/Independent Living Units," (218-RICR-50-00-2); and "Business Enterprises Program Regulations," (218-RICR-50-00-3)).

i. The RI Veteran's Home, RI Veterans Cemetery, and State Veterans Office of Veterans' Affairs (VA) (See R.I. Gen. Laws Chapter 30-17.1 and Rhode Island Veterans Home: Administrative Procedures for the Billing and Collection of Maintenance Fees (180-RICR-10-00-2); RI Veterans Memorial Cemetery (180-RICR-20-00-1); and "Rhode Island Veterans Home: General Rules of the Rhode Island Veterans Home" (180-RICR-10-00-1))

j. Medicaid, including eligibility for and the scope, amount, and duration of any Medicaid-funded health coverage, services, and/or supports authorized by the state's Medicaid State Plan or Title XIX, Section 1115 research and demonstration waiver (See the Executive Office of Health and Human Services (EOHHS), R.I.

Gen. Laws § 42-7.2, Rhode Island Medicaid Code of Administrative Rules or MCAR)

k. Eligibility appeals, other than Large Employer Appeals, for HealthSource RI, the state's health benefits exchange, pursuant to R.I. Gen. Laws Chapter 42-157.

l. Programs and services offered through the Department of Behavioral Healthcare, Development Disabilities, and Hospitals to include individuals with behavioral health care needs and persons with developmental disabilities and any related institutional and home and community-based services as contained in R.I. Gen. Laws Title 40.1, "Rules and Regulations Licensing Procedure and Process for Facilities and Programs Licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals"; "Rules & Regulations Relating to the Definition of Developmentally Disabled Adult and The Determination of Eligibility as a Developmentally Disabled Adult"; "Rules and Regulations for the Licensing of Behavioral Healthcare Organizations."

m. Child protective and behavioral health services, child care, and foster care licensure and any related residential and community-based services. Department of Children, Youth, and Families (DCYF) programs and services as contained in R.I. Gen. Laws Chapter 42-72 and DCYF rules, standards, program policy and procedures. Family and juvenile court matters are not governed by this rule.

n. Assisted living residences and nursing facility transfers or discharges for all residents, both Medicaid and non-Medicaid.

2.1.4 DEFINITIONS

A. For the purposes of this rule, the following terms are defined as follows:

1. "Administrative hearing officer" means an impartial official authorized to preside over and decide a hearing involving a contested agency action, without regard to whether the official is an administrative law judge, a hearing officer or examiner, or other person designated by the Secretary to serve in this capacity.

2. "Administrative fair hearing" means a formal adjudication of a contested agency action in which an appellant can assert the right to a benefit, service, form of assistance, or good and to secure, in an administrative proceeding before an impartial hearing officer, equity of treatment under federal and state laws, rules, regulations, policies and procedures.

3. "Advance notice period" means the period of time prior to the effective date of most types of adverse agency actions. If a person appeals an agency action during this period, benefits or assistance continue or are reinstated until the appeal is resolved. This continuation or reinstatement is sometimes referred to as “aid pending.”

4. "Adverse action" means a final agency action subject to appeal, including but not limited to: any decision resulting in a change, limitation, termination, or denial of eligibility, the scope, amount, duration or delivery of assistance, the ability to practice or to provide a service, an adverse decision by a managed care entity (after exhausting internal appeals), a decision related to the Pre-Admission Screening Resident Review ("PASRR") Program as contained in 42 C.F.R § 431.201 (2016) or a decision that affects service planning or placement, or any other provision as set forth in § 2.1.3(A)(2) of this Part.

5. "Affected party" means the person or entity who is applying for or receiving benefits/services/assistance whether referred to as a beneficiary, recipient, enrollee, client, consumer, small employer, employer or member, as well as any person acting as the designated representative or “agent” (navigator, broker, etc.) of such a person or entity.

6. "Agency representative" is a person authorized by the state to take agency actions and, therefore, to be designated or assigned to represent the agency’s rules, policies, and positions in the appeal process.

7. "Agency/appeal response" means the explanation and rationale for the agency action subject to dispute. The agency/appeal response is prepared by an agency representative and cites the rule, policy, and/or statute that provides the legal justification for the action in dispute.

8. "Appeal process" means a proceeding that includes various forms of informal and formal dispute resolution. The intent of the appeal process is to ensure that agency actions are consistent with established federal and state laws, rules, regulations, policies, and procedures.

9. "Appeal record" means the appeal decision, all papers, documents, exhibits, and requests filed in the proceeding and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing.

10. "Appeal request" means a request by a person affected by an agency action to review and resolve a dispute of an agency action in an administrative fair hearing; or a desire to challenge agency delay or failure to act. An appeal request may also be filed to request a hearing to dispute

one or more general issues related but not limited to, agency policies, standards, practices, notice requirements, and/or performance.

11. "Appellant" means the affected party who is requesting an appeal. An appellant may be:

a. a person or

b. provider or

c. an individual who is an authorized representative of the appellant, either a legal guardian or an individual designated in writing by the person to represent their interests in an appeal or

d. a person or entity making an appeal on the behalf of an individual or class of individuals affected by an agency action.

12. "Assistance" means any cash payments, benefit, service or support, or benefit card, plan or package of services provided directly or by an authorized agent or contractor of a program administered by the health and human services agencies operating under the umbrella of the EOHHS. For the purpose of this rule, assistance has the same meaning as benefit(s), service(s), and support(s) irrespective of how provided or delivered.

13. "Complaint" has the same meaning as “grievance.”

14. "*De novo* review" means a review of an appeal without deference to prior decisions in the matter.

15. "Dispute" means the subject of disagreement or dissatisfaction with a final agency action that serves as the basis for an appeal.

16. "EHO" means the Executive Office of Health and Human Services Hearing Office which has been designated by law and the Secretary to serve as the appeals entity for programs administered by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, the Department of Children, Youth and Families, the Department of Human Services, the EOHHS and which may also have been designated under Rules and Regulations Pertaining to HealthSource RI (220-RICR-90-00-1) as the appeals entity for programs administered by HealthSource RI.

17. "*Ex parte* communication" means a written or oral communication about a matter on appeal that occurs between the members or employees of an agency assigned to render an order or to make findings of fact and conclusions of law in a contested case and any person or party to an appeal, or in connection with any issue of law, with any party or his or her representative, except upon notice and opportunity for all parties to

participate. But any agency member may communicate with other members of the agency and may have the aid and advice of one or more personal assistants.

a. *Ex parte* communications are prohibited except that communications with the hearing officer for the purpose of scheduling and other administrative functions are not considered to be *ex parte*.

18. "Formal dispute resolution" means a proceeding, such as an administrative fair hearing, before a qualified hearing officer, or a pre-hearing settlement conference in which both parties make a final effort to resolve the matter in dispute prior to the formal hearing.

19. "Grievance" means any complaint or dispute (other than a final agency decision or action) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a provider, regardless of whether remedial action is requested. A grievance is not an appeal request.

20. "HealthSource RI" or "HSRI" means the state's benefit exchange (also referred to as an "Exchange") established under R.I. Gen. Laws Chapter 42-157 and which meets the applicable standards of 45 C.F.R Part 155 (2012) and, as such, is authorized to make qualified health plans (QHPs) available to individuals and employers/employees who meet certain eligibility requirements. Unless otherwise identified, "HSRI" includes the individual market for qualified individuals and the Small Business Health Options Program (SHOP) serving the state's small group market for qualified employers /employees. The "Exchange" and "HSRI" have the same meaning for the purposes of this Part.

21. "Informal dispute resolution" means a discussion about the matter in dispute between an appellant and an agency representative. The informal dispute resolution process occurs while a contested agency action hearing is pending and excludes any involvement by the administrative hearing officer assigned to the case.

22. "Integrated Care Initiative" or "ICI" means a Medicaid initiative that delivers integrated and coordinated services to certain Medicaid and Medicaid and Medicare dual eligible beneficiaries through a managed care arrangement. Includes services from across the care continuum including primary, subacute, and long-term care.

23. "Involuntary discharges and transfers" means the relocation of a resident initiated by a licensed nursing facility or assisted living residence to another health care facility, residence, or non-institutional setting. The EHO is the designated appeal entity for such discharges and transfers without respect to payer.

24. “Modified Adjusted Gross Income” or "MAGI" means income used to determine eligibility for premium tax credits and other savings for marketplace health insurance plans and for Medicaid and the Children's Health Insurance Program (CHIP).

25. "Medicare-Medicaid Plan" or "MMP" is an integrated managed care plan under contract with the federal Centers for Medicare and Medicaid Services (CMS), EOHHS, and a managed care organization to provide fully integrated Medicare and Medicaid benefits to Medicare/Medicaid eligible (MME) beneficiaries.

26. "Pre-hearing settlement conference" means the formal dispute resolution option that takes the form of meeting, held prior to an administrative fair hearing, in which the affected party and a representative of the agency make a final effort to settle the appeal matters without having a formal adjudication. Not all agencies offer the option for a pre-hearing settlement conference in all situations.

27. "Recoupment" means the process in which an agency seeks to recover the cost for assistance provided to an affected party either in error or during the aid pending period if an adverse action is upheld in the disposition of an appeal.

28. "Small Business Health Options Program" or "SHOP" means a program operated by an Exchange pursuant to the ACA, 42 U.S.C. § 1311 and 45 C.F.R § 155.700 *et seq*. (2012). 45 C.F.R § 155.700 *et seq.* provides that a qualified employer may provide its employees and their dependents with access to one (1) or more QHP.

29. "Timely and adequate notice" means the formal notice sent by an agency to a person providing: a statement of an intended agency action that affects eligibility, the scope, amount, and/or duration of assistance; reasons and a legal citation for the action; the date the action will take effect, and an explanation of appeal rights and the process for requesting a hearing and, for some programs, obtaining legal representation. The notice must also identify the advance notice period when an adverse action is to be taken and the circumstances in which benefits/services/assistance may continue if a hearing is requested.

30. "Vacate" means to set aside a previous action.

2.2 Appeals: General Provisions

2.2.1 APPEAL PROCESS

A. The filing of an appeal initiates the hearing process. There are multiple opportunities to resolve an appeal while a hearing is pending.

1. Notification of Appeal Rights. An agency must include on all application forms – paper and electronic - a statement of the applicant's right to appeal and request a hearing related to any agency action related to eligibility; the process for determining eligibility; or a change in the scope, amount, or duration of assistance. Such notices must also state the:

a. Nature of the agency action, the legal basis for the action, the date the action takes effect, the right to representation, the process for review of agency documents if appealing and requesting a hearing, as well as the timelines and locations for doing so; and

b. Except for HSRI notices, information about continuation or reinstatement of assistance while an appeal is pending, as indicated in the aid pending provisions contained in § 2.2.2 of this Part.

2. Notices may contain an appeal request form, indicate the ways to obtain such a form, or provide information on the acceptable format for submitting an appeal if a form is not required or available. Individuals participating in publicly funded health and human services programs with eligibility administered through the state's web-based integrated eligibility system (IES) may have the option of obtaining all formal notices of agency action and other official communications through the user's private, secure online account created through the IES.

3. The state agency must not limit or interfere with an appellant's freedom to make a request for a hearing.

4. Procedures for Filing an Appeal. Appeal Request. An affected party may file an appeal in the format designated for such purposes, or in any other format allowed under applicable laws and regulations. The EHO will accept appeals via the state's web-based IES. An affected party may also download the EHO Appeal Form and file an appeal by traditional means (by postal mail, fax, or personal or commercial delivery). A complete and up-to-date appeal request form is located on the EOHHS website at: www.eohhs.ri.gov

a. An affected party may request assistance in filing an appeal by contacting the agency, the HSRI Contact Center (for enrollees in Medicaid or QHP via the state's web-based IES), or the EHO.

b. The appellant must provide an appeal request that states the reason(s) for the appeal.

5. Appeal Date –The appeal date determines whether aid pending is available and if the appeal was submitted in accordance with applicable timelines. If mailed, the appeal date is the date the form or letter is first

received by either the EHO or the agency. If the appeal is filed via telephone or fax, the appeal date is the date the contact is made with the agency or EHO. If the appeal is filed online through the appellant's account with the state's web-based IES, the appeal date is the date the appeal appears in the appellant's account.

6. Agency/Appeal response. The EHO is responsible for ensuring that all appeals are documented properly upon receipt in the electronic appeal database and referred, as applicable, for responses to the appropriate unit of the agency that took the action.

a. Components of the Response – The agency/appeal response is prepared by a representative of the agency and cites the rule, policy, procedure, and/or statute providing the legal justification for the agency action in dispute.

b. Confidentiality – The agency and/or the EHO must take whatever appropriate measures are necessary to ensure any private or confidential information contained in the appeal, and any response prepared, are protected properly to the full extent required by applicable federal and/or state laws, rules or regulations.

c. Agency/Program Specific Provisions – HSRI -- The EHO must inform HSRI as soon as possible of any appeals related to HSRI programs that are filed solely through the EHO. HSRI must be provided with the opportunity to respond to any such appeals and appear at the hearing even in circumstances in which another agency bears principal responsibility for preparing the agency/appeal response. Additional provisions on agency/program specific requirements located in § 2.4 of this Part.

7. Appeal Review. The EHO reviews the appeal to determine if it has been submitted in accordance with the applicable procedures and filing requirements and applicable federal and state laws, regulations, and/or rules.

a. Types of appeals -- For most health and human services programs, an appeal filed properly will result in a scheduled hearing. Exceptions include the circumstances identified in 42 C.F.R. § 431.220(a) related to changes in law or policy affecting an entire class of beneficiaries, or the appellant withdraws the appeal. Circumstances that shall provide an opportunity for a hearing include, but are not limited to:

(1) Affected party's claim for assistance is denied or not acted upon within the required timeframe;

(2) Affected party believes that an agency has acted erroneously in terminating, suspending, or reducing eligibility; or delaying the delivery of and/or terminating, suspending, or reducing the scope, amount, or duration of assistance or the manner in which it is delivered;

(3) Affected party believes that agency's determination related to initial screening, placement, periodic review, or intermittent or regular evaluation of a plan that initiates or affects access to assistance is erroneous or contrary to prevailing standards of practice.

(4) Affected party believes that the agency has limited the freedom to choose among providers without the appropriate federal and/or state authority;

(5) Affected party believes the agency erroneously calculated: the amount of assistance; a payment, or a contribution to the cost of assistance; or the required payment or reimbursement relative to prevailing agency rules, contract obligations, or other binding agreement;

(6) Affected party believes the agency's decision about placement, care planning, or case management, or choice of services is inappropriate, erroneous, or contrary to prevailing standards of practice;

(7) Affected party believes the agency's action with respect to licensure, certification, sanction, or scope of practice was made in error or inappropriately limits or restrains the ability to participate in a program or practice;

(8) Affected party claims discrimination based on age, disability, gender, sexual preference, race, religion, national origin, or color (additional specialized forms may need to be filed);

(9) Affected party believes agency indication of abuse or neglect unjustified or in error;

(10) Affected party believes a nursing facility or assisted living residence decision to transfer or discharge is erroneous;

(11) Affected party wishes to challenge the denial of coverage of, or payment for, health care/services based on

an interpretation of medical necessity criteria, prior-authorization rules, managed care rules; and/or

(12) Any program specific matters that the agency has identified publicly by rule or notice that qualifies as an agency action subject to appeal.

(13) Acknowledgement of an appeal – The EHO must send a timely acknowledgment to the appellant upon receipt of the appeal request. The acknowledgement must contain information about the formal and informal options for resolving the appeal including the administrative fair hearing process.

b. Duration – An appeal remains open until:

(1) An affected party voluntarily withdraws it and the withdrawal is confirmed without undue delay by the EHO in writing; or

(2) An affected party or an affected party's representative fails to appear at a scheduled hearing, without good cause (as below); or

(3) A hearing has been held and a decision made.

8. Incomplete appeals. Upon receipt of an appeal request that fails to meet the requirements of this section and/or other applicable federal or state laws, regulations, and/or rules, the EHO or agency must, promptly and without undue delay, send written notice informing the affected party:

a. The appeal request has not been accepted;

b. The reasons for determining the appeal request incomplete;

c. If there is any cure for the defects in the appeal request and the timeline in which the appellant may submit an amended appeal.

9. Agency/program Specific Requirements. For both HSRI and Medicaid, appeals must be filed pursuant to § 2.2.1(A)(4) of this Part within thirty (30) days of the contested agency action. The 30 days begins five (5) days after the mailing date of the notice of an intended agency action. See § 2.4 of this Part for special provisions related to the Office of Child Support Services and long-term care facility/resident actions.

2.2.2 CONTINUATION OR REINSTATEMENT OF AID PENDING RESOLUTION OF AN APPEAL

A. An appellant may receive the continuation or reinstatement of eligibility or assistance in certain types of cases if an appeal is filed in the advance notice period, before an agency action takes effect. Requirements related to aid pending are as specified below:

1. Advance Notice Period. The State must institute aid pending in situations in which timely and adequate notice are not provided.

B. Agency Responsibilities. Upon determining a request for aid pending is valid, except for HSRI, a representative of the agency or EHO must provide information about the following:

1. Consequences – The person receiving aid pending must be advised of the consequences of reinstating/continuing assistance during the appeal. See table in § 2.2.2(C) of this Part for an overview of possible consequences if an adverse action is upheld on appeal.

2. Scope and duration – At the time aid pending is initiated, the appellant must be informed that assistance will be continued until a hearing decision is rendered, unless:

a. A determination is made at the hearing that the sole issue is one of a change in state or federal law, regulation/rule or policy, as indicated in 42 C.F.R. § 431.220(a); or

b. Another agency change affecting the appellant's assistance occurs while the hearing decision is pending and the appellant fails to request a hearing on the second issue after notice of that change.

3. Agency/Program-specific provisions – The appellant must be provided with notification of any special provisions related to aid pending that may affect in any way the delivery of the assistance while the appeal is pending. Agencies shall also abide by the provisions set forth in § 2.4 of this Part.

C. Summary of Aid Pending – The following table summarizes aid pending requirements, responsibilities, and possible consequences by agency/program:

State Agency Administering Program	Name of Program	Advance Notice Period	Potential Consequence – Adverse Action Upheld
(a) Department of Human Services	General Public Assistance (GPA)	10 days from the mail date. Appeal request must be accompanied by or include	

State Agency Administering Program	Name of Program	Advance Notice Period	Potential Consequence – Adverse Action Upheld
		a written statement asking specifically for continuation of GPA to stay the reduction, suspension, or discontinuance until the fair hearing decision is issued.	Repayment may be required.
(b) Department of Human Services	Supplemental Nutrition Assistance Program (SNAP)	10 days from the mail date	SNAP benefits discontinued at the end of the certification period. Recoupment initiated.
(c) Department of Human Services	RI Works	10 days beginning on the fifth day after the date on the notice of intended action. If the advance notice period ends on a holiday or weekend, beneficiary is entitled to aid pending if appeal is received on the day after the holiday or weekend.	Repayment required and recoupment is initiated. For RI Works participants, appeal period may count toward time-limits
(d) Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals	All programs and services	10 days beginning on the fifth day after the date on the notice of intended action	
(e) Health Source RI – health benefit exchange	Qualified Health Plans, Advance Premium Tax Credits and Cost Sharing Reductions, the Small Business	Within 30 days of the eligibility redetermination occurring	Reconciliation of advance receipt of premium tax credits which may require the repayment of advanced premium

State Agency Administering Program	Name of Program	Advance Notice Period	Potential Consequence – Adverse Action Upheld
	Health Options Program		tax credits or otherwise impact a federal tax return. Payment of premium to carrier.
(f) Executive Office of Health & Human Services	All Medicaid	10 days beginning on the fifth day after the date on the notice of intended action	Repayment for Medicaid- funded services required. Recoupment or estate recovery initiated.
(g) Executive Office of Health and Human Services	Nursing facility and assisted living transfers/discharges	10 days beginning on the fifth day after the date on the notice of intended action	

2.2.3 Continuation or Reinstatement of Benefits After the Effective Date of Action

A. Where the beneficiary requests a hearing more than ten (10) days after the date of the intended action, the beneficiary's services may be continued or reinstated until a final agency decision is rendered after the hearing if the beneficiary provides verification, in the form of a signed statement with supporting documentation, of one of the following circumstances:

1. The beneficiary's life, health, or safety will be seriously impacted by the loss of benefits.

2. The beneficiary was unable to request a hearing before the date of action due to the beneficiary's disability or employment.

3. The beneficiary's caregiver or their authorized representative was unable to request a hearing before the date of action due to their health or employment.

4. The beneficiary did not receive the state's or designated service agencies notice prior to the effective date of the intended action.

B. If a Medicaid beneficiary is receiving aid pending, after appealing a decision that he/she is no longer Medicaid eligible, said beneficiary shall continue to

receive the Medicaid benefits that were being received when the appeal request was filed.

2.2.4 ALTERNATIVE DISPUTE RESOLUTION OPTIONS

A. State and federal laws require that public agencies make alternative informal and formal dispute resolution options available to an appellant.

B. The mix of informal and formal options is generally as follows with the exceptions noted:

1. Informal Dispute Resolution Options. Each agency provides appellants with one or more informal options for resolving an appeal while the hearing process goes forward. The informal dispute resolution process involves a discussion between the appellant and one or more representatives of the agency that took the action.

2. Voluntary - - Participation in informal resolution is entirely voluntary on the part of the appellant. If the informal resolution process is successful and the contested agency action does not advance to a hearing, the informal resolution decision is final and binding. Administrative hearing officers do not participate in informal settlement conferences.

3. Disposition Related to Agency Errors – When it is determined through the informal resolution process that an agency error was the basis for an action under appeal, the appeal may be disposed as follows:

a. Agency Response Amended. Supporting documentation from the affected party may be entered into the agency response and retained as part of the record.

b. Notice of Corrected Action. Until such time as the appellant receives the updated notice and the appropriate action is in effect, the appeal remains open.

c. Appeal Withdrawal. The appellant is required to withdraw the appeal even if it is determined during the informal resolution process that the original eligibility decision was incorrect.

C. Formal Dispute Resolution Options – An appellant may opt to by-pass the informal process entirely or proceed in incremental steps to the formal resolution options. The administrative fair hearing process is initiated when an appeal is filed and, as such, is the principal formal option.

D. Pre-hearing settlement conference – An appellant may choose to pursue a pre-hearing settlement conference as a formal dispute resolution option when an agency and circumstances allow. The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) and the EOHHS often make

this option available upon request to beneficiaries and providers. The pre-hearing settlement conference functions as follows:

1. Presiding Settlement Conference Officer. A pre-hearing settlement conference is presided over by an impartial hearing officer designated by the EHO. The presiding officer acts as a mediator between the appellant and agency and, in this capacity, endeavors to establish a settlement agreement, satisfactory to both parties, to serve as a disposition to the contested agency action.

2. Review of Case and Proposed Settlement. The presiding officer reviews the appeal and the agency's response and the terms of any proposals that may be offered to resolve the dispute with the agency and the appellant and/or their legal representatives.

3. Components of Settlement Agreement. The settlement agreement must contain the terms for resolving the appeal, implementing any corrective actions required, withdrawing the appeal and closing the contested agency action as outlined in § 2.3.3 of this Part.

4. Disposition of the Case. If accepted by all parties, the settlement agreement is final and binding and must be implemented in the terms established without due delay. If no agreement is reached, the contested agency action proceeds to a formal adjudication in an administrative fair hearing, as outlined § 2.3 of this Part.

E. Administrative Fair Hearing – The dominant formal dispute resolution mechanism is an administrative fair hearing as specified in detail in § 2.3 of this Part.

2.3 Administrative Fair Hearing Process

2.3.1 GENERAL PROVISIONS

A. The administrative hearing process is initiated when an agency or the EHO receives an appeal request.

B. The EHO is responsible for scheduling the date for the appeal hearing. Upon scheduling a hearing, the EHO must send a written notice to the appellant of the date, time, and location or format of the hearing, no later than fifteen (15) days prior to the hearing date. The EHO must also notify all other affected parties including any authorized representatives of the hearing date.

C. The EHO must assure that the appellant is sent an evidentiary packet, upon request, at least three (3) days in advance of the hearing date, except when using the expedited appeal process. The evidence packet shall, at a minimum, include:

1. Except for HSRI, in eligibility cases, the appellant's original application, the eligibility decision, and, if available, verification results from third party data sources used to make the eligibility determination;

2. In all other cases, any documents provided to the agency by or on behalf of the appellant that were material to the action taken by the agency;

3. Any documents and explanations provided by the appellant;

4. The agency response where applicable;

5. All associated notices.

D. The evidence packet is available to all parties in attendance at the hearing. All parties may request an opportunity to view the evidence packet prior to the hearing, with sufficient advance notice prior to the scheduled hearing. Requests to review the evidence packet should be made to the EHO.

E. The appellant and/or an authorized representative of the appellant must appear for the hearing at the scheduled time, date, and location. Hearings are held typically on the EHO or agency premises or may be conducted by telephone.

1. Request for continuance – If the appellant or an authorized representative is unable to appear for the hearing, the appellant must contact the EHO prior to the hearing date to report that he or she will not be able to appear, explain the reason, and request a continuance/postponement of the hearing.

a. No more than two (2) requests for continuances are permitted, unless the EHO allows, in its discretion, to permit an additional continuance subsequent to a valid claim of good cause as indicated below in § 2.3.1(E)(3) of this Part.

b. A SNAP household may receive one postponement of no more than 30 days.

c. A hearing may be held open to a later date, at the discretion of the hearing officer, if an appellant requests additional time in which to submit relevant documents.

2. Dismissal for Failure to Appear – If the appellant or an authorized representative does not provide prior notification to the agency or the EHO of an inability to appear, the appeal is dismissed unless there is an approved claim of good cause. If good cause is found, the dismissal is vacated and the hearing is rescheduled as below.

3. Good Cause for Failure to Appear – Good cause for failure to attend a hearing is liberally interpreted in the appellant's favor. EHO staff may assist the appellant in the establishment of good cause, and when necessary, forward determining information to the hearing officer. If the hearing officer determines that good cause exists, the hearing is rescheduled within thirty (30) days of the request and benefits/assistance/services must be reinstated without undue delay if terminated due to dismissal of the appeal. Good cause claims include, but are not, limited to:

a. Sudden and unexpected event (such as loss or breakdown of transportation, illness or injury, or other events beyond the individual's control) which prevents the appellant's appearance at the hearing at the designated time and place; or appearance at the wrong office;

b. Disabilities, such as linguistic and behavioral health limitations, that may affect the appellant's ability to attend;

c. Injury or illness of appellant or household member that reasonably prohibits the individual from attending the hearing; and

d. Death in family.

4. Vacating a Dismissal – Upon determining that good cause exists, the dismissal is vacated, the hearing is rescheduled, and the EHO provides appropriate notification to the affected parties and agency. If the EHO finds that good cause does not exist, timely written notice of the denial of a request to vacate a dismissal is sent to the appellant. In HSRI appeal cases, the appellant must be advised in the notice in either case – denial or approval of request to vacate a dismissal – of the right to pursue the appeal at the federal level. An appellant choosing to exercise this right must make a request to the federal DHHS appeal entity in no more than thirty (30) days from the date of the EHO notice indicating whether the dismissal is vacated.

F. The appellant may designate anyone, including someone who is not licensed to practice law, to serve as an authorized representative during the appeal process. The appellant may make this designation to the EHO or the agency in-person or in writing by fax, email or U.S. mail or, as appropriate, the state's web-based IES.

1. Role of the Authorized Representative – Once the designation has been recognized by the EHO, the authorized representative is copied on all correspondence pertaining to the appeal that is provided to the appellant. Although the authorized representative may act on behalf of the appellant in all matters leading up to, and including, formal adjudication in a fair

hearing, the appellant may opt to participate on his or her own in any dispute resolution proceeding.

2. Legal representation – In situations in which the appellant chooses to engage a licensed attorney to serve as an authorized representative, the EHO must be notified in advance that the attorney intends to make an appearance on the appellant's behalf. Such notification must be provided directly to the EHO by the attorney.

3. Authorized representatives who are out-of-state attorneys must file a *pro hac vice* motion in Rhode Island Supreme Court to request to be temporarily admitted to practice prior to providing legal representation in the administrative appeal process. In addition, all out-of-state attorneys must meet the requirements of the Rhode Island Supreme Court's Article II, Rule 9 (requirements for non-resident attorneys).

4. If an appellant chooses to have legal representation at the hearing, the representative shall file a written "Entry of Appearance" with the EHO at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the legal representative access to the appeal record. The Entry of Appearance is also needed for the EHO to confirm the representation for purposes of follow-up, review, requests for continuances, etc.

G. Persons attending the hearing typically include the appellant, the appellant's authorized representative, the EOHHS Hearing Officer, state attorneys, and one or more representatives from the agency that took the action on appeal. In instances in which the subject on appeal is a change in agency policy, other affected parties may also have representatives in attendance.

1. Agency representatives attending the hearing must be prepared to answer questions related to the action on appeal.

2. It is the responsibility of the hearing officer to record the attendance of all persons who were involved in the relevant action under appeal.

H. All parties, authorized representatives, witnesses, and other persons present at a hearing must conduct themselves with the same decorum commonly observed in any Rhode Island court. Where such decorum is not observed, the hearing officer may take any appropriate actions to restore order, including ejection of parties or adjournment, as appropriate.

I. No person who is a party to or a participant in any proceeding before the agency or EHO or the party's counsel, employee, agent, or any other individual, acting on the party's or their own or another's behalf, is permitted to communicate *ex parte* with the hearing officer. The hearing officer must not request or entertain any such *ex parte* communications. These prohibitions do

not apply to those communications that relate solely to general matters of procedure and scheduling.

J. Hearing officers hear the case *de novo* (or with no prior knowledge of the specific issue) and base decisions on applicable laws, regulations, rules and procedures.

K. Persons with disabilities must have access to services and processes necessary to ensure their full participation in the hearing process.

L. In compliance with state and federal statutes and regulations, EHO must have interpreters available for persons with limited English proficiency and other persons needing such services, such as a telephonic interpreter service or a language line.

M. The EHO administrative hearing officer is an impartial designee of the Secretary of EOHHS. Accordingly, a person who has participated in any way in the matter on appeal – either in an official or unofficial capacity – is prohibited from serving as a hearing officer. The hearing officer is responsible for eliciting all relevant facts bearing on the appellant's claim and agency rules, regulations, policies, and/or procedures pertinent to the matter in dispute.

N. The EHO maintains an official transcript of oral presentations made in the hearing. If not transcribed, any tape recording and any memorandum prepared by a presiding official summarizing the contents of those presentations shall be maintained on file. This is the official record for matters appealed from the EOH. Any person who testifies at the hearing shall be sworn in by the hearing officer. An orderly procedure must be followed that includes but is not limited to the following:

1. A statement by the hearing officer reviewing the agency's purpose relative to the hearing; the reason for the hearing; the hearing procedures; the basis upon which the decision will be made, and the manner in which the individual is informed of the decision.

2. A statement by the appellant and/or authorized representative outlining the appellant's understanding of the matter in dispute.

3. A statement by an agency representative, setting forth the legal basis for the agency's action that specifies applicable rules, regulations, policies, and/or procedures.

4. A full and open discussion of all facts and policies at issue by participants under the active leadership of the hearing officer.

O. The hearing may be adjourned from day to day or, within reason, held open to a later date at the discretion of the hearing officer if the appellant has reason to

believe that he or she will obtain further relevant information to present at the hearing.

P. The appellant may submit supporting documents into evidence in-person at the time of the hearing, by mail, or by fax, the time frame for such being at the discretion of the EHO.

Q. The EHO must provide the appellant with the opportunity to:

1. Review the appeal record, including all documents and records to be used by agency at a reasonable time of no less than 72 hours before the date of the hearing, as well as during the hearing;

2. Bring witnesses to testify;

3. Establish all relevant facts and circumstances;

4. Be informed of the right to judicial review, if dissatisfied with the hearing decision;

5. Present an argument without undue interference;

6. Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses;

7. Testify telephonically upon request of the appellant and/or at the discretion of the EHO;

8. For HSRI actions, an appellant shall be informed of the right to appeal further to the federal HHS, if dissatisfied with the hearing decision; and

9. For appeals related to HSRI and MAGI Medicaid, an appellant must be informed that a hearing decision affecting one household member may require eligibility re-determinations for other household members.

R. The EOHHS Hearing Officer considers all relevant evidence presented during the course of the appeals process, including any evidence introduced at the formal hearing. Only information bearing directly on the issue under review and the policy, regulation or law put forth as supporting the agency action may be presented by the agency. The hearing officer is prohibited from reviewing any information that is not made available to all parties to the appeal. Further, the hearing officer is prohibited from reviewing any records or evidence that have not been introduced at the hearing.

S. When a hearing involves medical documentation required by federal or state law, such as a diagnosis, a physician’s report, or a medical review team’s decision, a medical assessment from a qualified person (other than the person(s)

involved in the original decision) may be obtained at the expense of the agency and integrated into the appeal record if the hearing officer deems it necessary.

T. No evidence is admitted after completion of a hearing or after a case is submitted on the record, unless the hearing officer allows the record to remain open for such limited purpose, or the hearing officer reopens the hearing, or the parties agree to the submission, and all the parties have been notified of allowing the record to remain open or said reopening.

2.3.2 APPEAL HEARING DECISIONS

A. The full responsibility of the EHO in the hearing process is discharged when a final decision has been made, in writing, by the EHO.

B. The hearing decision must include a full report of the findings and the applicable provisions stipulated in federal and/or state policies, rules, regulations, and/or procedures and any additional relevant evidence presented during the course of the appeals process, including at the hearing, that serve as the basis for the decision.

C. The hearing decision must include findings of fact and conclusions of law, separately stated, and a concise statement of the underlying facts supporting the findings. The hearing decision must include a plain language description of the effect(s) of the decision on the appellant and, when applicable, members of the appellant's household. In addition, the EHO must indicate in writing that the appeals decision is final, unless the appellant chooses to exercise the right to pursue legal action through the RI court system or, in HSRI cases, appeal to the federal DHHS as indicated in § 2.4.4 of this Part. For exceptions to this requirement, see § 2.4.6 of this Part.

D. The EHO must issue written notice of the decision to the appellant within ninety (90) days of the date the appeal request is received, unless otherwise indicated in the program-specific special provisions indicated in § 2.4 of this Part. The EHO must provide notice of the appeal decision and implementation instructions to the agency pertaining to the continuation, reinstatement, or termination of benefits/assistance/services or any required changes in the scope, amount, and/or duration of benefits/assistance/services.

E. In accordance with 7 C.F.R. § 273.15(c)(l), the state agency has sixty (60) days from the receipt of a SNAP beneficiary's request for a hearing to:

1. conduct the hearing;

2. reach a decision; and

3. notify household and agency.

F. The EHO is responsible for assuring that the written decision is disseminated to the following:

1. Appellant/Authorized representative;

2. Agency representatives, including caseworker if there is one, and the associate director and administrator of the agency unit/division responsible for implementation of the action in dispute;

3. Chief legal counsel assigned to the agency, if applicable;

4. Agency Administrative Rules Coordinator, if applicable; and

5. Any other such interested persons or parties that may be involved directly in the decision's implementation.

G. The hearing responsibility of the state agency is considered discharged when the following steps have been completed:

1. The hearing officer renders a written decision, based exclusively on evidence and other material introduced at the hearing, on behalf of the state agency.

2. Copies of the decision are distributed to the appellant, the agency representatives including specific case managers, program administrators, and department senior staff as appropriate, and other interested parties. The decision must set forth the issue, the relevant facts brought out at the hearing, the pertinent provisions in the law and state agency policy, and the reasoning which led to the decision; and

3. Action required by the decision, if any, has been completed by the agency, and confirmed in writing to the EHO.

H. The table below provides an overview of special hearing requirements by agency and program:

Special Hearing Requirements

State Agency Administering Program	Name of Program	Deadline for Hearing (From Date Appeal is Received)	Hearing Decision Due
(01) Department of Human Services	General Public Assistance (GPA)	Unspecified	90 days from date the appeal request is received

Special Hearing Requirements			
State Agency Administering Program	Name of Program	Deadline for Hearing (From Date Appeal is Received)	Hearing Decision Due
(02) Department of Human Services	Child Support Services	Unspecified	30 days from date of close of hearing
(03) Department of Human Services	Supplemental Nutrition Assistance Program (SNAP)	60 days from date appeal request is received	60 days from date appeal request is received
(04) Department of Human Services	Office of Rehabilitative Services	60 days from the date appeal request is filed Note: Requests for informal resolution must take place within days of the appeal request and within 30 days of hearing date	30 days from the date of the close of the hearing
(05) Department of Human Services	Division of Elderly Affairs, Home and Community-based Services	14 days from date the appeal request is received	90 days from the date the appeal is received
(06) Department of Human Services	All Other DHS Programs including Child Care Assistance, and the State-funded Supplemental Security Program	90 days from the date the appeal is received	90 days from the date the appeal is received
(07) Department of Children, Youth, & Families	Findings of Abuse and Neglect	120 days from date appeal request is received	120 days from date appeal request is received

Special Hearing Requirements			
State Agency Administering Program	Name of Program	Deadline for Hearing (From Date Appeal is Received)	Hearing Decision Due
	Other programs	180 days from date appeal request is received	120 days from date appeal request is received
(08) Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals	Non-Medicaid Programs	15 days from the date the appeal is received	25 days from date of close of hearing
(09) HealthSource RI – health benefit exchange	Qualified Health Plan, Advanced Premium Tax Credits and Cost Sharing Reductions	Varies – See § 2.4.3 of this Part	Varies – See § 2.4.3 of this Part 90 days of the date of the appeal request as administratively feasible
(10) Executive Office of Health & Human Services	Medicaid	90 days from date appeal is received unless expedited	90 days from date appeal is received unless expedited See § 2.4.3 of this Part for expedited appeal requirements
(11) Executive Office of Health and Human Services	Nursing Facility/Assisted Living Transfers and Discharged	Varies – see § 2.4.7 of this Part	10 days from the date of close of a hearing unless expedited. If expedited, see § 2.4.2 of this Part

2.3.3 OPPORTUNITIES FOR FURTHER RECOURSE

A. An appeal decision is final and is the last step in the state's administrative adjudication process for resolving a contested agency action. Not all available remedies are exhausted once the appeal decision is final, however. Therefore, an appellant also must be informed by the EHO of the opportunity to pursue recourse through other legal channels if dissatisfied or aggrieved by the appeal decision as follows:

1. The appellant may file a complaint requesting judicial review of the appeal decision by the appropriate state court with jurisdiction pursuant to R.I. Gen. Laws § 42-35-15, as amended. The filing of such a complaint does not automatically stay the decision or order unless so ordered by the Superior Court.

2. Court proceedings for review are instituted by filing a complaint in the Superior Court of Providence County or in the Superior Court in the county in which the cause of action arose, or where expressly provided by the general laws in the sixth division of the district court or family court of Providence Count within thirty (30) days after mailing notice of the final decision of the agency, or if a re-hearing is requested, within thirty (30) days after that decision thereon.

3. Copies of the complaint shall be served upon the state agency and all other parties of record in the manner prescribed by applicable procedural rules within ten (10) days after it is filed in Court; provided, however, that the time for service may be extended for good cause by order of the Court.

4. Within thirty (30) days after the service of the complaint, or within further time allowed by the Court, the state agency shall transmit to the reviewing Court the original or a certified copy of the entire record of the proceeding under review.

5. Agency/program Specific Reviews as set forth in § 2.4 of this Part.

2.3.4 AGENCY FOLLOW-UP REGARDING APPEAL DECISIONS

A. After the appeal hearing is held and a decision is reached, the Administrative Hearing Office prepares a written document containing the elements identified above in § 2.3.2(C) of this Part. The EHO is responsible for the appropriate dissemination of the decision and providing any additional instructions to the agency that may be necessary to ensure the decision's timely and proper effectuation.

B. The EHO provides public access to all appeals decisions, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, including the redaction of personally identifiable information.

1. Redacted EOHHS hearing decisions, rendered in accordance with its record retention schedule, are available for examination upon request at the EHO.

2. EOHHS may, at its discretion, make redacted hearing decisions available on a publicly accessible website in lieu of, or in addition to, making them available at the central office.

2.3.5 CORRECTIVE ACTION

A. In accordance with 42 C.F.R. § 431.246, the state agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility if:

1. The hearing decision is favorable to the applicant or beneficiary; or

2. The state agency decides in the applicant's or beneficiary's favor before the hearing.

B. If the EHO decision upholds the state agency's action, a claim against the household for any over issuances shall be prepared in accordance with 7 C.F.R. § 273.18 by DHS.

2.3.6 APPEAL RECORD

A. The EHO is responsible for developing and maintaining the appeal record.

B. The appeal record consists of:

1. The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;

2. All papers and requests filed in the proceeding; and

3. The recommendation or decision of the hearing officer.

4. All pleadings, motions, intermediate rulings;

5. Evidence received or considered;

6. A statement of matters officially noticed;

7. Questions and offers of proof and rulings thereon;

8. Proposed findings and exceptions;

9. Any decision, opinion, or report by the EHO;

10. All staff memoranda or data submitted to the EHO or members of the agency in connection with their consideration of the case.

C. The EHO must make the appeal record accessible to the appellant within a reasonable time, at a convenient place, in accordance with all applicable requirements of federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

2.3.7 MOTIONS

A. General – Any party may request of the EHO any order or action not inconsistent with law, this rule and/or the Rhode Island Superior Court Rules of Civil Procedure.

1. Motions may be made in writing at any time before or after the commencement of a pre-hearing conference or hearing, and/or may be made orally during a pre-hearing conference or hearing. Each motion must set forth the grounds for the desired order or action and state whether oral argument is requested. Certain types of motions are prohibited by law or regulation for various assistance programs. The administrative fair hearing officer is responsible for ensuring all parties to the case are notified accordingly and that the applicable laws and regulations are equitably applied.

2. Within ten (10) business days of the filing of a written motion, an opposing party must file a written objection to the granting of the motion, and shall, if decided, request oral argument.

3. A hearing officer shall be assigned to determine whether oral argument on the motion is warranted and, if oral argument shall be heard, assign a date, time and place for such an argument. The hearing officer may decide a motion without argument if the motion involves a matter as to which the presentation of testimony or oral argument would not advance his or her understanding of the issue involved, or if disposition without argument would best serve the public interest. The hearing officer may act on a motion when all parties have responded thereto, or the deadline for responses has passed, whichever comes first, but no later than thirty (30) days following the filing of the motion.

B. At any time after the issuance of an appeal decision any party may, for good cause shown, by motion petition for a reconsideration of the final order. The petitioner shall file his/her motion within ten (10) days of the issuance of an appeal decision and shall set forth the grounds upon which he/she relies.

2.3.8 APPELLANT RIGHTS AND RESPONSIBILITIES

A. The agency or the EHO acting on the agency's behalf must ensure that appellants are aware of their rights and responsibilities once an appeal is filed and the hearing process is initiated.

B. Appellant Rights. It is the responsibility of the State to inform the appellant of the following:

1. Review of Evidence – The appellant has the right to examine all documents and records to be used at the hearing, at a reasonable time of no less than 72 hours before the date of the hearing, as well as during the hearing.

2. Representation – The appellant has the right to self-representation and/or representation by a third party such as a friend, relative, or legal counsel.

3. Case Presentation – The appellant may present the case without undue interference and bring any witnesses and submit any evidence he or she deems necessary to support the case. The appellant also has the right to question or refute any testimony or evidence at the hearing including, but not limited to, the opportunity to cross-examine witnesses.

4. Voluntary Withdrawal Procedure – An appeal may be withdrawn voluntarily in writing or by telephone by the appellant at any time. Appeals also may be withdrawn by telephone or on-line for certain programs as follows:

a. HSRI QHP/SHOP, Medicaid - Appeals may be withdrawn by the appellant only by calling the Contact Center or through a person's online account.

b. SNAP Appeals - SNAP appellants may make a verbal request to withdraw a hearing. In such SNAP cases, the administrative hearing officer assigned to the appeal must send written notice within ten (10) days confirming the withdrawal and providing the household with an opportunity to request or reinstate the appeal and request for a hearing within ten (10) days from date of the confirmation notice.

C. Appellant Responsibilities. Once the appeal has been initiated, the appellant is responsible for the following:

1. Hearing Appearance – The appellant or the authorized representative acting on the appellant's behalf must appear at the scheduled hearing. Failure to appear without good cause is considered "abandonment of hearing," as described in § 2.3 of this Part, and results in the closure of the contested agency action (except in SNAP cases), and dismissal of the request for a hearing.

2. Withdrawal of Appeal – In cases where the appellant no longer wishes to proceed with the appeal or where the informal resolution process is successful, the appeal may be withdrawn at the appellant's request.

3. Truthful and Accurate Information – The appellant must attest to the truthfulness and accuracy of information and materials presented during the appeal process and during the administrative fair hearing. Deliberate misrepresentations or omissions for the purposes of influencing the outcome of a contested agency action are treated as fraud and, as such, are subject to any applicable penalties established in state and federal laws, rules and regulations.

4. An appellant is responsible for notifying and keeping the EHO and the agency apprised of any changes in address and contact information.

2.3.9 EHO/APPEAL ENTITY ROLE AND RESPONSIBILITIES

A. The agency subject to the appeal or the EHO must fulfill certain responsibilities as the appeal entity.

1. Appeal Tracking – Notwithstanding the manner in which an appeal is submitted the EHO creates a record of the appeal. Hearing requests are tracked, scheduled, and managed while the appeal is pending and until a final decision is issued, or the appeal is withdrawn or resolved.

2. Hearing and Alternative Dispute Resolution Opportunities – An opportunity for an administrative fair hearing is granted to an affected party who submits an appeal.

3. Notice of Hearing – When a hearing is scheduled, EOHHS sends a written notice to the appellant of the date, time, and location or format of the hearing, no later than fifteen (15) days prior to the hearing date unless specifically stated otherwise in this Part.

4. Truthful and Accurate Information – State agency representatives are bound to provide truthful and accurate accounts of the basis for the agency action and the materials presented at the hearing.

5. Dismissal of an Appeal – The EHO shall dismiss an appeal when the appellant:

a. withdraws the appeal request orally or in writing, as is required by applicable law; or

b. fails to appear at a scheduled hearing without good cause;

c. the appeal is resolved in the informal dispute resolution process; or

d. dies while the appeal is pending (For HSRI only).

2.4 Agency/Program Specific Appeal and Hearing Provisions

The EOHHS Hearing Office is bound by federal and/or state law and regulations to recognize the unique appeal provisions applicable to persons participating in the following programs and/or delivery systems.

2.4.1 AID PENDING

A. See § 2.2.2 of this Part for additional information related to the continuation or reinstatement of Aid Pending the resolution of an appeal.

B. HSRI – Commercial Health Insurance through HSRI Renewals.

1. HSRI. Aid Pending is available to customers who appeal an eligibility redetermination. Eligibility redetermination shall be defined in accordance with 45 C.F.R. § 155.330(e)(1)(ii) (December 22, 2016) and 45 C.F.R. § 155.335(h)(1)(ii) (March 8, 2016) not to include later amendments thereto. Aid Pending is available to customers who appeal eligibility redetermination.

C. For appeals pertaining to General Public Assistance (GPA), a written request for hearing made within the ten (10) day advance notice period and must be accompanied by or include a written request for continuation of GPA to stay the reduction, suspension, or discontinuance until the administrative fair hearing decision is issued. Only at the applicant/recipient's specific written request must the agency continue GPA benefits.

D. If an appeal of resident discharge or transfer is filed within ten (10) days from the date of the notice of intended action, a resident may continue residing in the facility until the EHO administrative hearing decision is issued.

2.4.2 MEDICAID MANAGED CARE PLAN APPEALS – EOHHS

A. Medicaid beneficiaries enrolled in certain managed care delivery systems must attempt to resolve disputes unrelated to eligibility (disenrollment, prior authorization denial, change in the amount of a covered service, access to a particular provider, etc.) through the managed care plan's grievance and appeal process before requesting a hearing through the EHO.

B. The timelines for filing an appeal listed in the table in § 2.3.2(H) of this Part are suspended while the matter is on review with the managed care plan. However, a Medicaid beneficiary retains the right to request an Administrative Fair Hearing through the EHO, in accordance with the provisions set forth in § 2.3.1 of this Part if the matter remains unresolved after exhausting all remedies available through the managed care plan's grievance and appeals process. The final

federal managed Medicaid rules allow beneficiaries 120 calendar days to request a fair hearing.

C. The rules governing grievances and appeals may vary by type of managed care plan and population served and are specified accordingly in the applicable sections of the MCAR as follows:

Medicaid Managed Care Appeals Not Related to Eligibility		
Medicaid Managed Care Delivery System	**Managed Care Plan Grievance and Appeal Process**	**Applicable Parts**
a) RIte Care Plans – Neighborhood Health Plan, United and Tufts	Medicaid beneficiary once enrolled as a plan "member" must exhaust plan grievance and appeal process before requesting hearing through EHO.	210-RICR-30-05-2 Scope of Services Plan Appeal Process Member Rights
b) Rhody Health Partners – Medicaid Affordable Care Coverage Group Adults Age 19-64	Medicaid beneficiary once enrolled as a plan "member" must exhaust plan grievance and appeal process before requesting hearing through EHO.	210-RICR-30-05-2 Scope of Services Plan Appeal Process Member Rights
c) RIte Share Premium Assistance Program	Medicaid beneficiary must appeal issues in accordance with commercial plan appeals and grievance process. Appeals on all other matters, including cost- sharing and failure to enroll, and any coverage issues that remain unresolved must be made to EHO.	210-RICR-30-05-3 Scope of Program Program and cooperation requirements

Medicaid Managed Care Appeals Not Related to Eligibility		
Medicaid Managed Care Delivery System	**Managed Care Plan Grievance and Appeal Process**	**Applicable Parts**
d) Rhody Health Partners – Persons who are aged, blind or with disabilities	Medicaid beneficiary must exhaust levels I and II of managed care plan's grievance and appeals process before requesting a hearing through EHO. For MCO contracts starting on July 1, 2017, Medicaid beneficiary must exhaust one level of managed care plan's grievance and appeals process before requesting a hearing through EHO.	§ 40-10-1 of this Title, RHP Benefit Package § 40-10-1.2.6 of this Title, Grievances, Appeals and Hearings
e) Community Health Team – RI.	Medicaid beneficiary must file appeals related to medical services directly to the EHO. If contracted entity, overseeing delivery option, fails to resolve non-medical formal appeals within set timelines, Medicaid beneficiary may request hearing through EHO.	§ 40-10-1.26.3 of this Title, Service Delivery Options § 40-10-1.41.7 of this Title, Grievances, Appeals and Hearings
f) Medicare Medicaid Plan (MMP)	Medicaid/Medicare beneficiary must exhaust level I of managed care plan's appeals process before requesting a hearing through EHO for Medicaid services or overlap services covered by both Medicare and Medicaid.	§ 40-10-1.41.8 of this Title, MMP Benefit Package § 40-10-1.41.7 of this Title, Grievances, Appeals, and Hearings

2.4.3 EXPEDITED APPEAL – MEDICAID, HSRI, LTSS, SNAP

A. A Medicaid appellant may request an expedited appeal in circumstances when the matter in dispute cannot reasonably be resolved during the standard appeals process without jeopardizing the appellant's life, health, or ability to obtain the services required to attain, maintain, or regain maximum function.

B. A long-term services and supports (LTSS) expedited appeal may also be granted in instances in which a state licensed nursing facility or assisted living residence initiates a transfer or discharge of a resident due to either:

1. the planned closure of the facility/residence; or

2. the resident has failed, after reasonable and appropriate notice, to pay for a stay in the facility/residence.

C. An HSRI customer may request an expedited appeal when there is an immediate need for health services because the standard appeal could jeopardize the appellant's life, health, or ability to attain, maintain, or regain maximum function.

D. A request for an expedited appeal shall include information supporting the claim that a standard appeal could jeopardize the appellant's life, health, safety, welfare, or ability to attain, maintain or regain maximum function.

E. The EOHHS Hearing Office shall review all expedited appeal requests upon receipt and, as appropriate, require the agency or LTSS provider that initiated the action to prepare and return a response to the EHO in three (3) business days or less in instances involving dual-eligible beneficiaries enrolled in Medicaid managed care. (See § 2.4.3(F) of this Part).

F. If the EHO exercises its reasonable discretion and grants an expedited appeal, hearings are scheduled as follows:

1. Health Coverage Appeals – In instances in which the appellant is enrolled in affordable care coverage (QHP through HSRI or Medicaid) or is being involuntarily discharged/transferred from a long-term care facility in the circumstances indicated in §§ 2.4.8(C) and (D) of this Part, the hearing must be scheduled expeditiously and the decision must be issued without undue delay, taking into account the appellant's condition, the immediacy of the need for the health care access or coverage in dispute, and the extent to which any delays in the adjudication process may jeopardize the well-being or pose risks to the appellant or affect the efficacy of the health care access or coverage in dispute.

2. Dually Eligible Beneficiaries – If the appellant is a dually eligible Medicare-Medicaid beneficiary, a hearing must be scheduled immediately and appeal must be resolved in no more than three (3) business days from the date the EHO received the expedited appeal request.

G. If the request for an expedited appeal is denied, the EHO shall notify the appellant of this decision without undue delay by either telephone or other commonly available electronic media; a letter shall also be sent to the appellant explaining the reasons for the denial. Denial of a request for an expedited appeal

does not delay or otherwise disrupt the timeline for resolving the dispute through the standard appeal process.

H. EHO shall expedite hearing requests from households, such as migrant farmworkers, that plan to move from Rhode Island before the administrative hearing decision would normally be reached. Hearing requests from these households shall be processed faster than others if necessary to enable them to receive an administrative hearing decision and restoration of benefits if the administrative hearing decision so indicates before they leave Rhode Island.

I. SNAP. The State agency shall expedite hearing requests from households, such as migrant farmworkers, that plan to move from the jurisdiction of the hearing official before the hearing decision would normally be reached. Hearing requests from these households shall be processed faster than others, if necessary, to enable them to receive a decision and a restoration of benefits if the decision so indicates before they leave the area.

2.4.4 HSRI FEDERAL REVIEW OPTION

A. As the state entity recognized by the U.S. Department of Health and Human Services (DHHS) for implementing the federal components of the ACA, HSRI, and the EHO acting as the appeal entity on the agency's behalf, shall afford appellants certain specific rights prior to and after an administrative hearing decision is rendered.

B. If related to an HSRI action, the EHO shall provide an explanation of the appellant's right to pursue the appeal before the federal DHHS appeals entity within thirty (30) days of the date of the notice of the administrative hearing decision. The federal DHHS appeals process provides the appellant with an additional opportunity for informal resolution and a formal administrative hearing.

C. As applicable, EHO shall transmit, via secure electronic interface, the appellant's appeal record, including the appellant's records from HSRI, to the DHHS appeals entity. The appellant shall also be informed that seeking federal review is not a prerequisite for seeking judicial review unless or until a court with appropriate jurisdiction finds otherwise.

1. Upon receiving notice from the EHO of an administrative hearing decision overturning an agency action, the HSRI shall promptly implement the administrative hearing decision. Specifically, such an administrative hearing decision shall be effective:

a. Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with 45 C.F.R. §§ 155.330(f)(2) or (3) (2012) (not including later amendments) and in accordance with R.I. Gen. Laws §§ 42-35-3.2(a)(1) and (d); or

b. Retroactively, to the date the incorrect agency action became effective, at the option of the appellant.

2. HSRI must, pursuant to 45 C.F.R. § 155.545(c)(2) (2012) (not including later amendments) and in accordance with R.I. Gen. Laws §§ 42-35-3.2(a)(1) and (d)) redetermine the eligibility of household members who have not appealed the agency action, but whose eligibility for coverage and/or advanced premium tax credits or reductions in cost sharing may be affected by the appeal decision, in accordance with the standards specified in 45 C.F.R.§ 155.305 (2012) not including later amendments.

3. IRS Role – Decisions related to an award or level of advance premium tax credits must include a plain-language statement that the final calculation of tax credits is conducted by the federal Internal Revenue Service (IRS) through the reconciliation process, in accordance with section 36B(f) of the Internal Revenue Code (26 U.S.C. § 36B(f)), and that decisions or interpretations of the EHO are not binding against the IRS during that process.

2.4.5 HSRI SMALL BUSINESS HEALTH OPTIONS PROGRAM ("SHOP")

A. HSRI operates the SHOP to provide small employers with the opportunity to offer their employees with the option to obtain affordable health coverage through one or a choice of qualified health plans. The EHO has been designated as the entity responsible for handling appeals of SHOP actions initiated by SHOP employers and employees.

B. All SHOP employer and employee valid appeal hearings shall be conducted in accordance with 45 C.F.R. § 155.740, 45 C.F.R. §§ 155.505(e) through (g) (2012) not including later amendments, and 45 C.F.R. §§ 155.510(a)(1), (a)(2), and (c) (2012) not including later amendments.

1. An employer or employee wishing to appeal denial of eligibility by HSRI shall do so within ninety (90) days of the date on the notice of the action being taken by the agency. Such appeals may be filed through the EHO or the HSRI Contact Center by mail, telephone, or in person.

C. SHOP appellants, whether an employer or employee, have the right to request an alternative form of dispute resolution known as a “desk review" in lieu of an in-person hearing. In this option, the administrative hearing officer reviews written submissions and evidence provided by the appellant and agency representative(s) and any applicable statutes, rules and regulations used as the basis for the agency action. The hearing officer then issues an appeal decision based on the findings of this review.

1. To request a desk review, the appellant shall notify the EHO or HSRI Contact Center in advance and as follows:

a. If the hearing has already been scheduled, the request for the desk review shall be provided to the EHO or HSRI in no less than five (5) business days before the hearing date. In such cases, the written submissions from both parties – agency and appellant – shall be provided to the EHO on the day the hearing is scheduled to occur.

b. If the hearing has not yet been scheduled, the appellant may request the desk review at any time. Written submissions in such instances are due to the EHO within ten (10) days of the date the request is made or at such other time as may be agreed to by the affected party, the agency, and the EHO.

2. Upon requesting a desk review, the appellant forfeits the opportunity for an in-person hearing. The agency and the EHO are responsible for ensuring that the appellant is aware that the in-person hearing option has been forfeited and provide information related to any US DHHS and judicial review opportunities.

2.4.6 DHS OFFICE OF REHABILITATIVE SERVICES – APPEAL DECISION REVIEW AND IMPLEMENTATION

A. The Office of Rehabilitative Services, of the Rhode Island Department of Human Services, sets forth the due process procedures and process for handling contested agency actions, including opportunities for pre-settlement conferences as provided for in ORS rules and regulations. Either party in an ORS contested agency action may request a review of the appeal decision of the hearing officer within twenty (20) days after the date the decision is rendered. If neither party requests this review, the decision of the hearing officer becomes the final decision of the agency on the 21st calendar day after the decision is issued.

B. Director's Review – The impartial review of the hearing officer's decision when requested is conducted by the Director of the Department of Human Services.

1. Review Standards —The following standards of review apply when conducting a review of the appeal decision and the agency action in dispute:

a. Evidence. Each party is given an opportunity for the submission of additional evidence and information relevant to the issue;

b. Basis for Decision. The reviewing official is prohibited from overturning or modifying the decision of the hearing officer, or part of the decision that supports the position of the applicant or eligible individual, unless the Director concludes, based on clear and convincing evidence, that the decision of the hearing officer is clearly erroneous and contrary to:

(1) The approved ORS State Plan;

(2) The Rehabilitation Act of 1973, 29 U.S.C. § 701 *et seq*. as amended, including regulations, rules, policies, or procedures that are consistent with implementing the Act; or

2. The DHS Director shall render a final decision within thirty (30) days of the initial request to review.

3. The reviewing official shall provide a written decision to both parties.

C. If a party brings a civil action to challenge a final decision of an impartial hearing officer or to challenge a final decision of the Director's review, said decision shall be implemented pending review by the court.

D. Any individual aggrieved by the final agency decision may:

1. Bring a civil action for review of such decision in a United States district court of competent jurisdiction without regard to the amount in controversy, or

2. File for judicial review in accordance with R.I. Gen. Laws § 42-35-15 as amended by filing a complaint in the Superior Court of Rhode Island.

2.4.7 DHS CHILD SUPPORT SERVICES APPEALS

A. The DHS Office of Child Support Services (OCSS) is the state agency charged with establishing and enforcing child support obligations. In this capacity, the OCSS is responsible for determining the paternity of children, issuing court orders for financial and medical support, modifying or changing orders when appropriate, and enforcing child support obligations on the behalf of persons participating in the state's Medicaid, RIWorks, and Child Care Assistance programs. Accordingly, program participants have the right to dispute OCSS actions that affect their child support through the appeal and hearing process set forth in §§ 2.3 through 2.4 of this Part, with the exceptions provided as follows:

1. As the state's principal child support agency, OCSS appeal and hearing requests must concern matters that are within the agency's jurisdiction. Disputes related to eligibility or the scope, amount, and/or the duration of benefits/assistance/services must be directed at the agency with the statutory responsibility for administering and thus taking such actions. Therefore, for an OCSS appeal to be considered valid, it must meet the filing requirements established in § 2.2.1(A) of this Part and address agency actions related to:

a. Amount of support paid;

b. Date such payment was made;

c. Date such payment was received by the applicable state agency or RI Family Court;

d. Date and amount of pass-through and/or child support paid; and

e. Pass-through payments that were not made and the reason for non-payment.

B. The OCSS sends a quarterly notice to program participants with child support obligations that shall include, at a minimum, information about any such actions and a participant's right to appeal and request a hearing for any that may be in dispute and when a pass-through payment was not sent in a particular month an explanation as to why the payment was not made.

C. In instances in which a contested agency action proceeds to a formal administrative hearing, the appellant is advised that the EHO shall send a written decision via US Mail that includes any remedies required on the part of the agency or the appellant in no more than (30) days following the close of the hearing. In the event that an OCSS action was found to be in error, the agency shall make any corrections required and issue a new quarterly notice containing information that reflects any changes that have been made as a result of the appeal.

2.4.8 INSTITUTIONAL AND COMMUNITY-BASED LONG-TERM CARE RESIDENT INVOLUNTARY DISCHARGES AND TRANSFERS

A. The Executive Office of Health and Human Services is the single state agency for Medicaid under Title XIX of federal law. In this capacity, the EOHHS has been designated as the appeal entity for resident discharges and transfers initiated by state licensed and federally certified nursing facilities and state licensed assisted living residences, without regard to payer. All such transfer/discharges that are taken by a provider without the written agreement or consent of the resident or the resident's legal guardian or authorized representative are considered to be involuntary and referred to hereinafter as such.

B. The provisions of this subpart apply only to involuntary resident discharges and transfers and irrespective of whether Medicare, Medicaid or private parties pay all or some of the costs for the resident's stay. State agency actions affecting Medicaid eligibility or Medicaid-funded long-term services and supports (LTSS) must be appealed through the process set forth in §§ 2.2 and 2.3 of this Part and/or, where applicable, the Medicaid managed care or expedited appeal provisions set forth in § 2.4.2 of this Part.

C. In accordance with applicable federal and state laws, regulations and rules, an involuntary transfer or discharge may only be initiated by a licensed entity as follows:

1. A resident transfer/discharge is permitted under applicable federal regulations when it is necessary for medical reasons; when the resident's health and/or safety or the health and safety of other residents or staff is endangered if the resident remains; when a resident – or the party responsible for the resident – has failed, after reasonable and appropriate notice, to pay for their stay at the facility; or in the event of a facility closure.

2. A resident transfer/discharge may be initiated in accordance with the regulations set forth in the RI Department of Health (RIDOH).

D. Both licensed nursing facilities and assisted living residences must provide a formal notice of the intent to transfer/discharge to the resident and/or resident's authorized representative.

1. If the resident has been in the facility or residence for more than thirty (30) days, at least thirty (30) days advance notice is required. If the resident's stay is less than (30) days, the notice of the intent to discharge/transfer must be sent as soon as feasible prior to the relocation date. The advance notice period begins on the fifth day from the date notice is mailed.

2. For the notice to be valid, it must be sent within the time limits indicated above and include the following written in plain language:

a. The reason for the transfer;

b. The effective date of the transfer;

c. Where the resident will be re-located;

d. Notice to the resident of the right to appeal and request a hearing through the EHO, designate someone, including legal counsel, to act as an authorized representative during the appeals process, and to review medical and other pertinent evidence.

e. Indicate that if the transfer/discharge is related to facility/licensure closure or non-payment or may pose imminent risk to a resident's health, a request for an expedited appeal should be filed within ten (10) days of the notice. The ten (10) day period begins on the fifth day after the notice mailing date.

f. Contact information for both the state's Long-term Care Ombudsman and the RIDOH Center for Health Facility Regulations

for the aged. Persons with behavioral health care conditions must be provided with information about the state's Mental Health Advocate and contact information for the RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals and persons with developmental disabilities must be provided with contact information for the Rhode Island Disability Law Center.

E. An appeal of an involuntary discharge must be filed in writing to the EHO during the thirty (30) day appeal period. An expedited appeal request may be filed and determined to be valid in instances involving non-payment by a third party (Medicaid or Medicare) and/or imminent risk to the resident, at the discretion of the EHO, if received within ten (10) days of the notice of the intent to transfer/discharge sent by the provider. To ensure timely resolution of such cases, the EHO must notify the provider upon the appeal's receipt that a written response must be prepared within the timelines specified in § 2.4.8(D)(1) of this Part.

F. The EHO must provide the nursing facility or assisted living residence with a copy of the appeal. The provider must prepare and return a response to the EHO in no more than seven (7) calendar days. In instances in which the EHO has approved a request for an expedited appeals process, the response must be prepared in accordance with the requirements of § 2.4.8(D)(1) of this Part.

G. If a resident's appeal request is submitted within ten (10) days of the date of the notice of intent to discharge/transfer, the resident is prohibited from being relocated pending the decision of the hearing officer, including in instances in which a continuation is granted beyond the date of the intended action. In all cases where the appellant remains in the facility pending the appeal, the hearing must be scheduled no later than thirty (30) days after the receipt of the request for appeal by the EHO. If the appeal decision is rendered prior to the date of the intended action but upholds the nursing facility's decision to discharge/transfer, the resident may remain in the facility until the date of the intended action.

H. Prior to issuing a notice, the provider and the resident may have attempted and exhausted all available informal dispute resolution options. Appeals to the EHO may only occur subsequent to the sending of the notice of intended action by the facility/residence.

I. The administrative hearing generally will be conducted at the appellant's facility/residence, unless otherwise requested by the appellant.

J. If not an expedited appeal, official notice of the hearing must be sent by the EHO to all parties involved at least ten (10) days prior to the scheduled hearing date. Expedited appeals proceed in accordance with the provisions in section § 2.4.3 of this Part.

K. The administrative hearing process proceeds in accordance with the provisions established in § 2.3 of this Part except as indicated herein and as follows:

1. An appellant may request a continuance of the appeal hearing by contacting the EHO prior to the date of the scheduled hearing. To the extent feasible, continued hearings must be rescheduled by the EHO for a date that is within forty (40) days from the date of the notice of intended action. The EHO may require an appellant seeking more than one rescheduling of the same hearing to provide good cause, as defined in § 2.3.1(E)(3) of this Part. Notice of the rescheduled hearing must be provided to the affected parties must be provided in a minimum of two (2) business days prior to the date of the rescheduled hearing.

2. The EHO administrative hearing office must issue a decision in no more than ten (10) days from the date of the hearing.

L. In instances in which an appellant does not remain in a facility or residence during an appeal, a hearing must be conducted as soon as feasible but not more than ninety (90) days from the date the EHO receives the appeal. An appellant may request in writing one or more continuance(s) that extends beyond this date for the purposes of case preparation.

2.4.9 DCYF CHILD ABUSE AND NEGLECT APPEALS

A. Persons contesting an action of the Department of Children, Youth, and Families (DCYF) may file a complaint with the agency though the Central Office or Child Protective Services, in accordance with § 2.2 of this Part, or by-pass the complaint process and request an administrative hearing with the agency or the EHO.

B. In the case of a complaint related to an indicated finding of child abuse or neglect, a complaint sent to either the DCYF or the EHO initiates the appeal and hearing process. The affected party must send the original complaint explaining the manner in dispute along with the request for hearing directly to the EHO. Upon receipt, the appeal is handled in accordance with the provisions established in Part II related to preparation of agency response and the respective responsibilities of the appellant, the EHO and the agency.

C. At an Administrative Hearing on such a complaint, the EOHHS Hearing Officer determines whether the:

1. Department proved that abuse or neglect occurred by a preponderance of evidence; and/or

2. Agency representative that made the determination complied with all policy and procedures relating to the conduct of such investigation(s).

D. An appeal decision must be rendered and sent to the affected parties in no more than 120 days from the date the appeal was filed in cases in which a finding of an abuse or neglect offense disqualifies the appellant from employment in a child care position. For appeals on all other issues, the decision and notice must be rendered in no more than 180 days from the date the appeal was filed with the EHO.

2.4.10 EQUAL ACCESS TO JUSTICE ACT (EAJA) REQUIREMENTS

A. This section implements the statutory requirements contained in R.I. Gen. Laws Chapter 42-92, as amended, in order to provide equal access to justice for small businesses and individuals. This section governs the application and award of reasonable litigation expenses to qualified parties in adjudicatory proceedings conducted by, or under the auspices of, EOHHS.

B. It is EOHHS's policy that individuals and small businesses are encouraged to contest unjust administrative actions in order to further the public interest, and toward that end, such parties are entitled to state reimbursement of reasonable litigation expenses when they prevail in contesting an agency action which is, in fact, without substantial justification, as defined herein.

C. As used in this subsection, the following terms shall be construed as follows:

1. "Party" means any individual whose net worth is less than five hundred thousand dollars ($500,000) at the time the adversary adjudication was initiated; and any individual, partnership, corporation, association, or private organization doing business and located in the state, which is independently owned and operated, not dominant in its field, and which employs one hundred (100) or fewer persons at the time the adversary adjudication was initiated.

2. "Reasonable litigation expenses" means those expenses which were reasonably incurred by a party in adjudicatory proceedings, including, but not limited to, attorney's fees, witness fees of all necessary witnesses, and other costs and expenses as were reasonably incurred, except that:

a. The award of attorney's fees may not exceed one hundred and fifty dollars ($150) per hour, unless the hearing officer determines that special factors justify a higher fee;

b. No expert witness may be compensated at a rate in excess of the highest rate of compensation for experts paid by this state.

3. "Substantial justification" means that the initial position of the agency, as well as the agency's position in the proceedings, has a reasonable basis in law and fact.

D. Whenever a party prevails in contesting an agency action and has provided the state agency with timely notice of the intention to seek an award of litigation expenses as provided by law, the administrative hearing officer may request testimony, supporting documentation and evidence, briefs or other legal memoranda from the parties prior to making a decision.

E. The decision of the administrative hearing officer to make an award of reasonable attorney's fees shall be made part of the appeal record, shall include written findings and conclusions with respect to the award, and shall be sent to the claimant, unless the same is represented by an attorney, in which case the decision shall be sent to the attorney of record.

F. No other agency official may review the award.

G. The administrative hearing officer will not award attorney's fees or expenses if he/she finds that the agency was substantially justified in actions leading to the proceedings and in the proceeding itself.

H. The administrative hearing officer may, at his or her discretion, deny fees or expenses if special circumstances make an award unjust.

I. Whenever substantially justified, the administrative hearing officer may recalculate the amount to be awarded to the prevailing party, without regard to the amount claimed to be due on the application, for an award.

J. All claims for an award of reasonable litigation expenses shall be made by letter application supplied by the agency and shall be filed with the hearing office within thirty (30) days of the date of the conclusion of the adjudicatory proceeding which gives rise to the right to recover such an award. The proceeding shall be deemed to be concluded when the agency or administrative hearing officer renders a ruling or decision, there is an informal disposition, or termination of the proceeding by the agency.

K. The administrative hearing officer may, at his or her discretion, permit a party to file a claim not in keeping with the timeframe stated above upon a showing of proof and finding by such administrative officer that good and sufficient cause exists for allowing a claim to be so filed.

L. All claims must be postmarked or received by the hearing office if filed electronically, no later than thirty (30) calendar days from the date of the conclusion of the adjudicatory proceeding. These claims must contain:

1. A summary of the legal and factual basis for filing the claim;

2. A detailed breakdown of the reasonable litigation expenses incurred by the party in the adjudicatory proceedings, including copies of invoices, bills, affidavits, or other documents, all of which may be supplemented or

modified at any time prior to the issuance of a final decision on the claim by the administrative hearing officer;

3. A notarized statement swearing to the accuracy and truthfulness of the statements and information contained in the claim, and/or filed in support thereof. In this statement, the claimant must also certify that legal fee time amounts were contemporaneously kept.

M. Any party aggrieved by the decision to award or deny reasonable litigation expenses pursuant to the EAJA may bring an appeal to the Superior Court in the manner provided by the Administrative Procedures Act, R.I. Gen. Laws § 42-35-1 *et seq*.

2.4.11 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.

Chapter 10 - EOHHS General Provisions

Subchapter 05 - Consumer Rights, Responsibilities, and Protections

Access to Public Records (210-RICR-10-05-4)

4.1 LEGAL Authority

This Regulation is promulgated pursuant to R.I. Gen. Laws § 38-2-1 *et seq*. (Access to Public Records) and R.I. Gen. Laws § 42-35-2(a) (Administrative Procedures).

4.2 Definitions

A. As used herein, the following terms shall be construed as follows:

1. “Executive Office of Health and Human Services" or "EOHHS” means the state agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 et seq. within the executive branch of state government and serves as the principal agency for the purposes of managing the Departments of Children, Youth, and Families (DCYF); Health (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The EOHHS is designated as the “single state agency,” authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

2. “Public record” or “Public records” means all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, magnetic or other tapes, electronic data processing records, computer stored data (including electronic mail messages, except specifically for any electronic mail messages of or to elected officials with or relating to those they represent and correspondence of or to elected officials in their official capacities) or other material regardless of physical form or characteristics made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency.

4.3 Purpose

A. The purpose of this Regulation is:

1. To establish consistency with implementation of R.I. Gen. Laws § 38-2-1 *et seq*. and R.I. Gen. Laws § 42-35-2(a) relating to access to public records maintained by the Department of Human Services; Department of Children, Youth and Families; Department of Behavioral Healthcare, Developmental Disabilities and Hospitals; Division of Elderly Affairs; Division of Veteran's Affairs; and the Department of Health as detailed in the current Rules and Regulations Pertaining to Access to Public Records of the Department of Health;

2. To facilitate open and transparent government at the Department to the greatest extent possible, while balancing privacy rights of the public, employees and vendors of the State; and

3. To recognize the public's right to access public records while balancing an individual's right to be protected from an unwarranted invasion of personal privacy.

4. To provide the public with rules and procedures for accessing public records maintained by each of the State agencies set forth in § 4.2(A)(1) of this Part.

4.4 Policy

The Executive Office of Health and Human Services (EOHHS) recognizes both the public's right to access public records and the individual's right to dignity and privacy. It is the EOHHS policy to facilitate public access to all public records that may be disclosed in accordance with R.I. Gen. Laws § 38-2-1 *et seq*. It is also the policy of the EOHHS to ensure all public records under its jurisdiction be available for public inspection and reproduction consistent with all applicable state and/or federal law, unless otherwise prohibited by a court of competent jurisdiction.

4.5 Procedure for Requesting Public Records

4.5.1 Public Records

A. All records defined as public record in R.I. Gen. Laws Chapter 38-2 shall be open for public inspection during normal business hours of the Departments.

B. All requests for records shall be in writing unless readily available, or available under the Administrative Procedures Act, or prepared for the public. A written request to inspect or copy public records should be sent to the Division of Legal Services at the Department. Written requests may be mailed, hand delivered, e-mailed to the Department, or through the Access to Public Records page of the State of Rhode Island's Transparency Portal or another internet portal approved by the Department or sent via facsimile. Hand delivered requests may be made

during the Department's regular business hours. It is suggested, but not required, that requests be submitted on the form provided by the Department. Forms adopted by EOHHS to request to inspect and/or reproduce public records can be obtained at www.eohhs.ri.gov. In order to assure that the Department is able to respond to the request as efficiently and as completely as possible, the request should identify and describe the records being requested with as much specificity as possible. A written record of all requests will be maintained within each Division of the Department.

C. If the description of records sought in the request is not sufficient to allow the specific Department to identify and locate the requested records, the Department will notify the requestor that additional information is required. Nothing herein shall be construed as requiring the Department to reorganize, consolidate, or compile data not maintained by the Department in the form requested at the time the request to inspect such record is made except to the extent that such records are in an electronic format and the Department would not be unduly burdened in providing such data.

D. Any person seeking copies of public records may elect to obtain them in any and all media in which the Department is capable of providing them. If the Department maintains its records in a computer storage system, the Department shall provide any data properly identified in a printout or other reasonable format, as requested.

E. Nothing in this section shall be construed as requiring the Department to reorganize, consolidate, or compile data not maintained by the Department in the form requested at the time the request to inspect the public records was made except to the extent that such records are in an electronic format and the Department would not be unduly burdened in providing such data.

F. No records shall be withheld based on the purpose for which the Records are sought, nor shall the Department require, as a condition of fulfilling a Request, that a Requestor provide a reason for the Request or provide personally identifiable information about him/herself.

G. At the election of the person seeking records, the Department shall provide copies of the records electronically, by facsimile, or by mail in accordance with the person's choice, unless complying with that preference would be unduly burdensome due to the volume of records requested or the costs that would be incurred. The person requesting the records shall be responsible for the actual cost of delivery, if any.

4.5.2 Official Publications

Official publications, which the Department prepares in the discharge of duty to inform the public on matters of public interest, shall be furnished free of charge when available.

4.5.3 Copy of Rules and Regulations

The Department will supply one paper copy of its rules and regulations, on a particular subject, to an individual requesting the same, free of charge. Rules and regulations of the Department may also be available online on the Department's website and the Office of the Secretary of State website.

4.5.4 FEE FOR RECORDS

The Departments may charge a fee of fifteen cents ($.15) per page for documents copied on common letter or legal size paper. The Department will charge the reasonable actual cost for providing electronic records. A reasonable charge may be made for the search or retrieval of documents. Hourly costs for search and retrieval shall not exceed fifteen dollars ($15.00) per hour and no costs shall be charged for the first hour of the search and retrieval.

4.5.5 PAYMENT IN ADVANCE

All payments for copies shall be made in advance of or at the time of delivery or inspection of the requested documents. The Department shall inform the requesting person at the time a request for records is made, or as soon thereafter as possible, the approximate cost that will be incurred for the requested records, and the actual cost will be collected prior to delivery of the requested records. The Department may require the payment of the approximate costs prior to a search and/or retrieval to ensure that unnecessary costs are not incurred by the Department when the requesting party decides after the search and/or retrieval not to obtain the requested records.

4.5.6 Granting / Denying Requests

A. A request for records shall be granted if the above procedure has been followed and records sought are not specifically exempt from public disclosure. Any denial of the right to inspect or copy records shall be made in writing, giving the specific reasons for the denial, within ten (10) business days of such request.

1. For the purpose of computing time, the date that the state agency receives the records request is not counted in the total of ten (10) business days.

2. Any reasonably segregable portion of a public record excluded by R.I. Gen. Laws § 38-2-2(4) shall be available for public inspection after the deletion of the information which is the basis of the exclusion. If an entire document or record is deemed non-public, the Department shall state in

writing that no portion of the document or record contains reasonable segregable information that is releasable.

B. In the case of denial, the requestor may petition the Secretary for a review of the denial. The Secretary shall render her/his decision within ten (10) business days after submission of the review petition. If the Secretary also denies the request, or refuses to review the petition, or goes beyond the ten (10) business day limit, the person seeking the record may institute proceedings for injunctive or declaratory relief in the Superior Court or file a complaint with the Department of the Attorney General.

C. The inspection of public records must be accomplished in a manner which will provide for general supervision by authorized Departmental staff. This is necessary to prevent the misplacement or unauthorized removal of records or any other action which may impair the integrity of the public record.

D. Personnel in charge of the Division having possession of the public record requested shall have overall responsibility for the security of the public record. However, the individual in charge of that Division may designate a staff member(s) to coordinate the functions and responsibilities related to the copying and inspection of public records.

E. All personnel responsible for responding to requests for access to public records shall be made aware by their supervisors, of the provisions of this regulation and the procedures to be followed when an access to public records request is made. Department personnel having any questions regarding the procedures to be followed should direct inquiries to:

1. The person in charge of the Division or unit within the Department responsible for the activity/function to which the public record being requested relates; or

2. In the event that the public record cannot be readily categorized as falling under the responsibility of a specific Division or unit within the Department, the request should be directed to the Division of Legal Services which will serve as a resource in matters relating to the public's access to public records.

4.5.7 Requests for Extension of Time to Respond

A. There may be instances in which it takes the Department longer than ten (10) business days to search for and retrieve public records. In such cases, and for good cause shown, the ten (10) day time period to respond to the request may be extended an additional twenty (20) business days.

B. The Department shall provide written notice to the requestor that additional time is necessary to search for and retrieve responsive records and that the time period is being extended an additional twenty (20) days.

4.5.8 Non-Public records

A. Evidence submitted, and accepted, on a confidential basis in a pending department legal action shall not be available for public inspection. If a record contains both public and non-public information, the public portion will be available for inspection unless it cannot reasonably be segregated from the rest of such record.

B. The record shall, at all reasonable times, be available for inspection by the parties. Confidential, proprietary, or trade secret records, including any records qualifying as a non-public record under R.I. Gen. Laws § 38-2-2(4) shall, upon motion of a party and for good cause shown, be received at a closed hearing and not be released for public scrutiny.

C. Any such evidence received on a confidential basis shall not be subject to disclosure. The record of every contested case shall include the hearing notice, all pleadings, motions, all rulings, exhibits, evidence considered, statements of matters officially noted, proposed findings of fact and law and exceptions claimed thereto, decision and/or order, proposed decision and/or order.

4.6 Severability

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

Chapter 10 - EOHHS General Provisions

Subchapter 05 - Consumer Rights, Responsibilities, and Protections

Declaratory Order Petitions (210-RICR-10-05-05)

5.1 Purpose

This regulation states the requirements for submitting a request for Declaratory Order under R.I. Gen. Laws § 42-35-8(b), and the procedure for its consideration and prompt disposition.

5.2 Authority

This regulation is promulgated pursuant to the authority granted in R.I. Gen. Laws § 42-35-8.

5.3 Definitions

A. The following definitions shall apply to this regulation:

1. "Declaratory order" means an order issued by the State Agency that:

a. Interprets or applies a statute administered by the State Agency;

b. Clarifies whether a rule, guidance document, or order issued by the State Agency applies to a Petitioner; or

c. Clarifies how a rule, guidance document, or order issued by the State Agency applies to a Petitioner.

2. "Petition" means a request for a Declaratory Order.

3. "Petitioner" means a person requesting a Declaratory Order.

4. "State Agency" means the Executive Office of Health and Human Services (EOHHS).

5.4 Request for Declaratory Order: Form and Submission

A. A request for Declaratory Order must be in writing and include the following information:

1. The name and address of the Petitioner;

2. A plain statement identifying the statute, rule, guidance document, or order at issue;

3. A detailed statement of all facts relied upon by the Petitioner;

4. A copy of any and all documents relied upon by Petitioner that are not otherwise accessible to the State Agency; and

5. A plain statement requesting a Declaratory Order, and further indicating whether Petitioner seeks:

a. An interpretation or application of a statute administered by the State Agency;

b. Clarification as to whether a rule, guidance document, or order issued by the State Agency applies to Petitioner; and/or

c. Clarification as to how a rule, guidance document, or order issued by the State Agency applies to Petitioner.

B. A request for a Declaratory Order must be submitted to: EOHHS Office of Legal Services, Hazard Building, Second Floor, 74 West Road, Cranston, RI 02920.

5.5 Consideration and Disposition of Request for Declaratory Order

A. The State Agency shall promptly consider and respond to the request for Declaratory Order as provided in R.I. Gen. Laws § 42-35-8(c).

1. Should the State Agency schedule the matter for further consideration, the State Agency shall notify Petitioner in writing of the anticipated date on which the State Agency will grant or deny the request for Declaratory Order.

B. The State Agency may, at its discretion:

1. Hold a hearing for further consideration and discussion on the Petition; or

2. Request further information or documents from the Petitioner necessary for the full evaluation of his or her petition.

C. A Petitioner may appeal the State Agency's final disposition of the request for Declaratory Order as provided in R.I. Gen. Laws § 42-35-15.

Chapter 10 - EOHHS General Provisions

Subchapter 05 - Consumer Rights, Responsibilities, and Protections

Petition for Promulgation of Rules (210-RICR-10-05-06)

6.1 Purpose

The purpose of this regulation is to prescribe the form of a petition for promulgation of rules pursuant to R.I. Gen. Laws § 42-35-6 and the procedure for its submission, consideration, and disposition.

6.2 Authority

This regulation is promulgated pursuant to the authority granted in R.I. Gen. Laws § 42-35-6.

6.3 Definitions

A. The following definitions shall apply to this regulation:

1. "Petition" means a request for the promulgation of a rule.

2. "Petitioner" means a person requesting a Declaratory Order.

3. "Promulgate" means the process of writing a new rule, or amending or repealing an existing rule.

4. "State agency" means the Executive Office of Health and Human Services (EOHHS).

6.4 Request for the Promulgation of a Rule

A. A request for the promulgation of a rule must be in writing and include the following information:

1. The name and address of the Petitioner;

2. A plain statement identifying the rule or proposed new rule at issue;

3. A detailed statement of all facts relied upon by the Petitioner;

4. A copy of any and all documents relied upon by Petitioner that are not otherwise accessible to the State Agency; and

5. A plain statement requesting the promulgation of a rule, and further indicating whether Petitioner seeks a new rule or the amendment or repeal of an existing rule.

a. In the case of a request for promulgation of a new rule or the repeal of an existing rule, the Petitioner shall identify the rule by title and/or Rhode Island Code of Regulations (RICR) citation.

b. In the case of a request for an amendment to an existing rule, the Petitioner must identify with specificity the proposed language to be added or removed by redlining or similar means.

B. A request for the promulgation of a rule must be submitted to: EOHHS Medicaid Policy Office, Hazard Building, Second Floor, 74 West Road, Cranston, RI 02920.

6.5 Consideration and Disposition of Request for the Promulgation of a Rule

A. The State Agency shall promptly consider and respond to the request for the Promulgation of a Rule as provided in R.I. Gen. Laws § 42-35-6.

B. The agency may, at its discretion:

1. Hold a hearing for further consideration and discussion on the Petition; or

2. Request further information or documents from the Petitioner necessary for the full evaluation of his or her petition.

C. A Petitioner may appeal the State Agency's final disposition of the request for the promulgation of a rule as provided in R.I. Gen. Laws § 42-35-15.

Chapter 10 - EOHHS General Provisions

Subchapter 05 - Consumer Rights, Responsibilities, and Protections

Conduct of Public Hearings (210-RICR-10-05-7)

7.1 Purpose

The purpose of this rule is to establish a defined set of procedures for the conduct of public hearings regarding proposed rulemaking by the Rhode Island Executive Office of Health and Human Services.

7.2 Authority

This regulation is promulgated pursuant to the authority granted in R.I. Gen. Laws § 42-35-2(a)(4).

7.3 Definitions

A. For the purpose of this regulation:

1. “Executive Office of Health and Human Services” or “EOHHS” means the state agency that is designated under the Medicaid State Plan as the single state agency responsible for the administration of the Title XIX Medicaid Program.

2. “Member of the public” means any individual, firm, business, corporation, association, partnership or other group.

3. “Presiding EOHHS official” means the employee conducting the public hearing.

4. "Public hearing" means the convening of members of the public and agency personnel for the purpose of obtaining public comment on proposed rulemaking.

5. “Proposed rulemaking” means a proposed new rule, proposed amendment to a rule, or proposed repeal of a rule as noticed pursuant to R.I. Gen. Laws § 42-35-2.7.

7.4 Procedure for Conduct of Public Hearings

A. Convening of a Public Hearing

1. Public hearings may be held at the election of the agency or as required pursuant to R.I. Gen. Laws § 42-35-2.8(c).

2. Notice of public hearings shall be issued in accordance with the provisions of R.I. Gen. Laws §§ 42-35-2.8 and 42-46-6, when applicable.

3. The public hearing shall be held at a time and place designated by the EOHHS.

B. Transcription

1. The public hearing shall be transcribed by a stenographer or audio recorded.

2. For public hearings, any official transcript, recording, or memorandum summarizing presentations prepared by an agency official shall be made part of the rulemaking record in accordance with R.I. Gen. Laws § 42-35- 2.3(b)(5).

C. Testimony

1. Oral Testimony

a. Members of the public may make oral testimony during the meeting.

b. Members of the public who wish to make oral testimony during the meeting are requested to sign their name on the speaker list. Members of the public will be called to testify in the order in which their names appear on the speaker list.

2. Written Testimony

a. Written testimony must be submitted via e-mail, fax, hand delivery or regular mail to: EOHHS, Medicaid Policy Office, Virks Building, 3 West Road, Room 315, Cranston, RI 02920.

D. Disruptive Conduct

1. Members of the public attending the public hearing shall not cause disruptions, including but not limited to: screaming, loud noises, and disorderly gesticulations, that interrupt or distract from the testimony of other members of the public or from the ability of the presiding EOHHS official to conduct the public hearing.

Chapter 20 - Medicaid Payments and Providers

Subchapter 00 - N/A

Medicaid Payments and Providers (formerly Medicaid Code of Administrative Rules, Section #0301) (210-RICR-20-00-1)

1.1 Legal Authority

A. The Rhode Island Medicaid Program provides health care coverage authorized by Title XIX of the Social Security Act (Medicaid law) and Title XXI (federal Children's Health Insurance Program (CHIP) law) as well as the State's Section 1115 demonstration waiver. To participate in the Medicaid program, health care providers must be certified and agree to abide by the requirements established in Title XIX, Title XXI, Rhode Island General Laws, and State and federal rules and regulations.

B. To qualify for federal matching funds, payments to certified providers for authorized services must be made in accordance with methodologies established by the State and approved for such purposes by the Secretary of the U.S. Department of Health and Human Services (DHHS) and/or the federal Centers for Medicare and Medicaid Services (CMS). The Secretary of the EOHHS is authorized to set forth in rule, contractual agreements, provider certification standards, and/or payment methodologies the requirements for obtaining federal financial participation established in federal laws, regulations, or other such authorities. This rule governs participation of and payments to health care providers participating in the Medicaid program.

1.2 Definitions

A. As used in this rule, the following terms and phrases have the following meanings:

1. "Provider" means an individual or entity including physicians, nurse practitioners, physician assistants, and others who are engaged in the delivery of medical/behavioral health care services, or ordering or referring for those services, and is legally authorized to do so by the state in which the provider delivers the services.

2. "Rhode Island Medicaid program" means a combined state and federally funded program established on July 1,1966, under the provisions of Title XIX of the Social Security Act, as amended (P.L. 89-97). The enabling State legislation is to be found at R.I. Gen. Laws Chapter 40-8, as amended.

3. "Secretary" means the Rhode Island Secretary of the Executive Office of Health and Human Services who is responsible for the oversight, coordination,

and cohesive direction of state-administered health and human services, including the Medicaid agency, and for ensuring all applicable laws are executed.

4. "State agency" means the Rhode Island Executive Office of Health and Human Services (EOHHS) which is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Title XIX Medicaid Program.

1.3 Medicaid Payment Policy

A. Medicaid is the payor of last resort. Community, public, and private resources such as federal Medicare, Blue Cross/Blue Shield, Veteran's Administration benefits, accident settlements, or other health insurance plans must be utilized fully before payment from the Medicaid program can be authorized.

B. Payments to physicians and other providers of medical services and supplies are made in accordance contractual arrangements with health plans or on a fee-for-service basis in accordance with applicable federal and State rules and regulations, the Medicaid State Plan, and the State's Section 1115 demonstration waiver.

C. Payments to Medicaid providers represent full and total payment. No supplementary payments are allowed, except as specifically provided in the contract. Direct reimbursement to recipients is prohibited except in specific circumstances to correct a denial that is reversed on appeal.

1.4 Long-term Care Facilities -- Surveys

A. The Rhode Island Department of Health surveys all Nursing Facilities (NF) and Intermediate Care Facilities for persons with Intellectual Disabilities (ICF/ID) for compliance with the federal participation requirements of the Medicare and Medicaid programs. As a result of these surveys, reports are issued for certification purposes which cite provider deficiencies, if any exist, together with appropriate plans of correction. Subsequent corrections of deficiencies are also reported.

B. Statements of provider deficiencies must be made available to the public as follows:

1. Nursing Facilities (NF) - To the extent permitted by law, reports are sent to the Social Security Administration (SSA) district office that covers the area in which the facility is located and the Medicaid agency.

2. Intermediate Care Facilities/Intellectual Disabilities (ICF/ID): Reports are sent to the Medicaid agency. The agency is required to send the reports for both Nursing and Intermediate Care Facilities to the appropriate Long-term Services and Supports (LTSS) Unit covering the district in which the facility is located. The agency must also send the ICF/ID reports to the SSA office covering the catchment area in which the facility is located.

C. These files are available to the public upon request. Material from each survey must be held at both the EOHHS and the LTSS Unit for three (3) years.

1.5 Medicaid Provider Administrative Sanctions

A. In accordance with R.I. Gen. Laws Chapters 42-35 (The Administrative Procedures Act), and 40-8.2, the EOHHS is authorized to establish administrative procedures to impose sanctions on providers of health services and supplies for any violation of the rules, regulations, standards, or laws governing the Rhode Island Medicaid Program. The federal government mandates the development of these administrative procedures for the Title XIX Medicaid Program in order to ensure compliance with Sections 1128 and 1128A of the Social Security Act, which imposes federal penalties for certain violations.

B. Sanctionable Violations. All providers of Medicaid and CHIP-funded health care services and supplies are subject to the R.I. Gen. Laws and the rules and regulations governing the Medicaid program. Sanctions may be imposed by the EOHHS against a Medicaid provider for any one (1) or more of the following violations of applicable law, rule, or regulation:

1. Presenting or causing to be presented for payment any false or fraudulent claim for medical services or supplies.

2. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than to which the provider is legally entitled.

3. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

4. Failure to disclose or make available to the Single State Agency or its authorized agent records of services provided to Medicaid recipients and records of payments made for such services.

5. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as determined by an official body of peers.

6. Engaging in a course of conduct or performing an act deemed improper or abusive of the Medicaid Program or continuing such conduct following notification that said conduct should cease.

7. Breach of the terms of a Medicaid provider agreement or failure to comply with the terms of the provider certification of the Medicaid claim form.

8. Overutilizing the Medicaid Program by inducing, furnishing, or otherwise causing a beneficiary to receive services or supplies not otherwise required or requested by the beneficiary.

9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid beneficiary referral.

10. Violating any provisions of applicable federal and State laws, regulations, plans, or any rule or regulation promulgated pursuant thereto.

11. Submission of false or fraudulent information in order to obtain provider status.

12. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

13. Conviction of a criminal offense for any intentional, reckless, or negligent practice resulting in death or injury to beneficiaries.

14. Failure to meet standards required by State or federal laws for participation such as licensure and certification.

15. Exclusion from the federal Medicare program or any state health care program administered by the EOHHS because of fraudulent or abusive practices.

16. A practice of charging beneficiaries or anyone acting on their behalf for services over and above the payment made by the Medicaid Program, which represents full and total payment.

17. Refusal to execute a provider agreement when requested to do so.

18. Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from the Single State Agency.

19. Formal reprimands or censure by an association of the provider's peers for unethical practices.

20. Suspension or termination from participation in another governmental health care program under the auspices of Workers' Compensation, Office of Rehabilitation Services, Medicare, or any State program administered by the EOHHS or one of the agencies under the EOHHS umbrella.

21. Indictment for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

22. Failure to produce records as requested by the state agency.

23. Failure to comply with all applicable standards set forth in the Medicaid Provider Manuals available online: http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual.aspx and as agreed to in the EOHHS Provider Agreement Contract.

24. Failure to repay or make arrangement for the repayment of identified overpayments or otherwise erroneous payments.

C. Provider Sanctions. Any one (1) or more of the following sanctions may be imposed against providers who have committed any one (1) or more of the sanctionable violations above:

1. Termination from participation in the Medicaid program or any state health care program administered by the EOHHS.

2. Suspension of participation in the Medicaid Program or any State health care program administered by the EOHHS or an agency under the EOHHS umbrella.

3. Suspension or withholding of payments.

4. Transfer to a provider agreement not to exceed twelve (12) months or the shortening of an already existing provider agreement.

5. Prior authorization required before providing any covered medical service and/or covered medical supplies.

6. Monetary penalties.

D. Prepayment audits will be established to review all claims prior to payment.

E. Initiate recovery procedures to recoup any identified overpayment.

F. Except where termination has been imposed, a provider who has been sanctioned may be required to attend a provider education program as a condition of continued participation in any health care program administered by EOHHS.

1. A provider education program will include instruction in:

a. claim form completion;

b. the use and format of provider manuals;

c. the use of procedure codes;

d. key provisions of the Medicaid Program;

e. reimbursement rates; and

f. how to inquire about procedure codes or billing problems.

1.6 Notice of Violations and Sanctions

A. When the Medicaid agency intends to formally suspend or terminate a provider as a consequence of a sanctionable violation, a notice of violation must be sent to the provider by registered mail. The notice must include the following:

1. A plain statement of the facts or conduct alleged to warrant the intended EOHHS action. If the Medicaid agency is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved and a detailed statement shall be furnished as soon as is feasible.

2. A statement of the provider's right to a hearing that indicates the provider must request the hearing within fifteen (15) days of the receipt of the notice.

B. Informal Hearing. Within fifteen (15) days after the receipt of a notice of an alleged violation and a sanction, the provider may request an informal hearing with the Medicaid agency.

1. This informal hearing provides an opportunity for the provider to discuss the issues and attempt to come to a mutually agreeable resolution, thereby obviating the need for a formal administrative hearing. Informal dispositions may also be made of any contested case by stipulation, consent order, or default.

C. Administrative Hearing. The right to an administrative appeal is conditioned upon the appellant's compliance with the procedures contained in this rule and the hearing will be held in compliance with the provisions of the State's Administrative Procedures Act, as found at R.I. Gen. Laws Chapter 42-35, as amended, and in conformance with the Medicaid Code of Administrative Rules, Section 0110, “Complaints and Appeals.”

D. Appeal for Judicial Review. Any provider who disagrees with the decision entered by the Hearing Officer as a result of the Administrative Hearing has a right to appeal for judicial review of the hearing decision by filing a complaint with the Superior Court within thirty (30) days of the date of the decision in accordance with R.I. Gen. Laws § 42-35-15.

E. Administrative Actions. Once a sanction is duly imposed on a provider, EOHHS shall notify the applicable state licensing agent and the federal Medicare Title XVIII program if appropriate, state health care programs as defined in Section 1128(h) of the Social Security Act (as amended), state-funded health care programs administered by the Medicaid agency, or any other public or private agencies involved in the issuance of a license, certificate, permit, or statutory prerequisite for the delivery of the medical services or supplies. Furthermore, EOHHS shall notify all affected Medicaid beneficiaries.

F. Stay of Order. Orders may be stayed in accordance with R.I. Gen. Laws § 42-35-15 and R.I. Gen. Laws § 40-8.2-17.

G. Reinstatement. Pursuant to 42 C.F.R. § 1002.214 Subpart C, a State may afford a reinstatement opportunity to any provider terminated or suspended at the State’s

initiative. The provider may only be reinstated to participate in the Medicaid program by the EOHHS, in its capacity as the Medicaid single state agency. The sanctioned provider may submit a request for reinstatement to EOHHS at any time after the date specified in the notice of termination or suspension.

H. EOHHS may grant reinstatement only if it is reasonably certain that the types of actions that formed the basis for the original exclusion have not recurred and will not recur. Factors EOHHS will consider in making such a determination are contained in 42 C.F.R. § 1002.215(a)(l)(2)(3) Subpart C.

I. If EOHHS approves the request for reinstatement, it will provide the proper notification to the excluded party and all others who were informed of the exclusion, specifying the date when participation will resume in accordance with 42 C.F.R. § 1002.215(b). If EOHHS does not approve the request for reinstatement, it will notify the excluded party of its decision. Any appeal of a denial of reinstatement will be in accordance with State procedures and not subject to administrative or judicial review.

1.7 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.

Chapter 20 - Medicaid Payments and Providers

Subchapter 00 - N/A

Medicaid Payments and Providers: Transportation Services (210-RICR-20-00-2)

2.1 Legal Authority

A. These rules and regulations related to the Executive Office of Health and Human Services' (EOHHS) Non-Emergency Medical Transportation (NEMT) Program are promulgated pursuant to the authority conferred under:

1. 42 C.F.R. § 431.53 "Assurance of Transportation";

2. 42 C.F.R. § 440 "Medicaid Program; State Option to Establish Non-Emergency Medical Transportation Program";

3. Section 1902(a)(70) of the Social Security Act ("Deficit Reduction Act of 2005");

4. R.I. Gen. Laws § 42-66-4(8) "Duties of the Department";

5. R.I. Gen. Laws § 42-12-1.3 "Transfer of Functions from the Department of Elderly Affairs"; and

6. R.I. Gen. Laws § 31-36-20(a) "Motor Fuel Tax Disposition of Proceeds."

B. Federal 42 C.F.R. § 431.53 requires the Medicaid agency:

1. to ensure necessary transportation for beneficiaries to/from health care providers; and

2. to describe the methods used to provide such transportation services.

2.2 Purpose and Overview

The purpose of this regulation is to set forth methods and requirements for the Non-Emergency Medical Transportation (NEMT) Program, the Elderly Transportation Program (ETP), and the transportation for recipients of Temporary Assistance to Needy Families (TANF).

2.3 Definitions

A. Wherever used in these rules and regulations, the following terms shall be construed as follows:

1. “Border communities” means the list of locations contained in § 2.20 of this Part.

2. “Curb-to-curb” means transportation of the beneficiary from the curb in front of his/her residence to the curb in front of the destination, including the return trip. The driver may assist the individual to get in and out of the vehicle.

3. “Door-to-door” means transportation of the beneficiary from the outside door of his/her residence to the outside door of his/her destination, including the return trip. “Door-to-door” is further defined herein to mean the transport of the beneficiary from the ground level door of his/her residence to the ground level door of his/her destination, including the return trip.

4. “Elderly”, as used herein, means persons aged 60 and older.

5. “Emergency transportation” means transportation to obtain emergency health care services for unforeseen circumstances which demand immediate attention at a hospital to prevent serious impairment or loss of life. Medically necessary emergency transportation must be provided by ambulance.

6. “Executive Office of Health and Human Services” or “EOHHS” means the state agency that is designated under the Medicaid State Plan as the single state agency responsible for the administration of the Title XIX Medicaid Program.

7. "Limited public motor vehicle" or "LPMV" means and includes every motor vehicle for hire, other than a jitney, as defined in R.I. Gen. Laws § 39-13-1, or a taxicab equipped with a taximeter used for transporting members of the general public for compensation only from a designated location on private property to such points as may be directed by the passenger.

8. “Medicaid-covered service” means the full scope of services and supports authorized by the Medicaid State Plan and the Section 1115 demonstration waiver. Although there is variation in benefits by coverage group, in general, Medicaid health coverage includes the benefits set forth in Part 10-00-1 of this Title, “Overview of the Rhode Island Medicaid and Children’s Health Insurance Program.”

9. “Medically necessary” means and includes medical/health visits that are part of a total patient plan of care supervised and ordered by a health care professional.

10. “Ride share program” means a transportation service provided through a Transportation Network Company (TNC) regulated by the Rhode Island Division of Public Utilities and Carriers under R.I. Gen. Laws Chapter 39-14.2.

11. "R.I. Gen. Laws" means the Rhode Island General Laws, as amended.

12. “Transportation management authority” means an entity that provides, or arranges to provide, transportation services to EOHHS beneficiaries and elderly non-Medicaid riders, as provided herein.

13. “Transportation provider” means an entity that transports EOHHS beneficiaries and elderly non-Medicaid riders, as provided herein, via public transit (bus), taxi, LPMV, ride share program, public motor vehicles, multi-passenger van, ambulance, or wheelchair van.

2.4 Transportation Services for Medicaid Beneficiaries

A. EOHHS recognizes that Medicaid beneficiaries need available and appropriate transportation in order to access medical care, and assures the provision of such transportation when required to obtain medically necessary services covered by the Medicaid program.

B. Transportation can be provided by any of the following modes, as appropriate to the needs of the individual. Public transit (bus) is the preferred mode of NEMT when both the beneficiary and the provider are within one-half (½) mile of an established bus stop and the beneficiary is able to walk or transport her/himself to the bus stop.

1. Public transit (bus)

2. Taxi or Limited Public Motor Vehicle (LPMV)

3. Ride Share Program

4. Public Motor Vehicles

5. Multi-Passenger Van

6. Ambulance

7. Wheelchair Van.

8. Mileage Reimbursement.

2.5 Covered Services

Covered Services - The Medicaid Program covers emergency and NEMT. Ground transportation is covered and provided for when the individual is a Medicaid beneficiary and is receiving a Medicaid-covered service.

2.5.1 Emergency Transportation

A. When medical services are obtained at a hospital participating in the Medicaid program, it is the responsibility of the hospital or emergency department staff to provide and pay for appropriate transportation home if needed.

B. For Medicaid managed care beneficiaries, emergency transportation is provided by the managed care organization. Billing for this service is through the managed care organization.

C. For Medicaid fee-for-service beneficiaries, emergency transportation is provided by the Medicaid fee-for-service program. Billing for this service is through the Medicaid fee-for-service program.

2.5.2 Non-Emergency Medical Transportation (NEMT)

A. NEMT is provided when the Medicaid beneficiary has no other means of transportation, no other community resource exists, such as family and friends, and transportation by any other means would endanger the individual's health or safety. NEMT may be provided by ambulance if this mode is medically necessary. A physician/clinician written statement or attestation will be required.

B. To be eligible for NEMT services, Medicaid beneficiaries must be unable to find alternative transportation and require transportation services for medical/health visits that are part of a total patient plan of care supervised and ordered by a health care professional.

1. Escorts

    a. If medically justified and communicated during the reservation to the State's transportation management authority, an additional person can be permitted to accompany a beneficiary.

    b. An escort must accompany all children under the age of 18 years.

    c. Adult beneficiaries who need transportation to their own medical appointments may have a child accompany them.

2. More than one beneficiary may be transported by the same vehicle on the same trip, provided:

    a. Adequate seating and safety restraints are available for all passengers.

    b. The health and safety of any of the passengers is not compromised.

    c. Passengers must not have their trip lengthened by more than 30 minutes due to increasing the number of passengers in the same vehicle.

2.5.3 Out-of-State Non-Emergency Medical Transportation

A. Transportation to communities that closely border Rhode Island may be provided for Medicaid-covered services and as pre-authorized by the transportation management authority subject to review and approval of the State, as needed. See § 2.20 of this Part for a list of border communities.

B. With the exception of transportation to communities that closely border Rhode Island, NEMT for out-of-state trips will only be considered for payment when the service is medically necessary and the Medicaid-covered service is either not available in Rhode Island or there are other extenuating medical circumstances.

C. All out-of-state NEMT, with the exception of NEMT to border communities, requires prior authorization from the State's transportation management authority.

2.5.4 Nursing Facility Residents

A. NEMT: An individual residing in a nursing facility whose condition precludes transportation by the facility vehicle to and from a physician's office, medical laboratory, hospitals, etc., may be transported for non-emergency medical services when:

1. Patient cannot be transported by any other means through the facility; and

2. Required medical service cannot be provided within the facility, such as portable x-ray services provided in a facility setting; and

3. Facility has exhausted all other alternative means (including transportation by family or friends) whenever possible.

B. Emergency medical transportation: services can only be provided when a patient is severely ill or injured and transportation by any other means would endanger the individual's health or safety.

2.6 Transportation Requests

All NEMT requests must be scheduled through the State's transportation management authority. Some requests may require a physician or clinician's attestation and/or documentation. Information on how to contact the State's transportation management authority is available at: www.eohhs.ri.gov.

2.6.1 Standing Order Requests

Regularly recurring appointments for which the beneficiary requires NEMT transportation may be scheduled with the State's transportation management authority. A licensed medical/behavioral health provider must request or modify the standing order.

2.7 Service Models

A. Curb-to-curb

B. Door-to-door

C. Wheelchair van: This service is for beneficiaries who are permanently confined to a wheelchair and cannot transfer out of it. Wheelchair-dependent beneficiaries must

provide their own wheelchair. A Hoyer Lift or two-person lift will be used to transfer the beneficiary. Beneficiaries must request this service at the time of reservation to the state's transportation management authority. Transportation providers are not permitted to enter the beneficiary's residence or the provider's office. Beneficiaries who will require additional assistance in leaving their destination or upon arrival at their medical appointment may bring an escort with them. Beneficiaries must inform the transportation management authority when they reserve transportation that an escort will accompany them.

D. Stretcher: A beneficiary who is confined to a bed, cannot walk, and cannot sit in a wheelchair may be transported by stretcher. The beneficiary must not require medical assistance during transport. The driver must enter residence and a clear, accessible path to the beneficiary must be available.

E. Basic Life Support (BLS) and Advanced Life Support (ALS): Transportation of a beneficiary who is confined to a bed, cannot walk, and cannot sit in a wheelchair requires medical assistance during transport. The driver must enter residence and a clear, accessible path to the beneficiary must be available.

F. Mileage Reimbursement

1. Personal vehicle mileage reimbursement is a payment to a friend, family member or volunteer who transports the recipient in his/her own vehicle. The reimbursement must be pre-approved by the State's transportation management authority and will be paid at the approved reimbursement rate which is the federal transportation mileage reimbursement rate.

2. Personal vehicle mileage reimbursement is available to transport an eligible Medicaid beneficiary to and from a Medicaid-covered service.

3. Trips will be validated by the State's transportation management authority.

2.8 Passenger Cancellations

A. Passengers must make every effort to keep their scheduled trip appointments. If unable to keep an appointment, notification must be provided to the State's transportation management authority at least twenty-four (24) hours prior to the scheduled trip.

B. If a medical appointment is cancelled the same day, or there are other unforeseen circumstances, the beneficiary should contact the State's transportation management authority as soon as possible.

2.9 Passenger No-Shows

A. Standing Orders

1. Passengers who frequently (more than three (3) instances per month) do not cancel their regularly scheduled trip appointment at least twenty-four (24) hours in advance may be required to schedule each trip separately at least two (2) days in advance and will no longer be eligible for "standing order" pick-ups.

2. After a sixty (60) day period, passengers may request reinstatement of eligibility for standing order and scheduled ride pick-ups without being required to confirm such trips in advance. Requests will be subject to EOHHS approval.

3. Passengers who frequently (more than three (3) instances per month) do not cancel other scheduled trips, such as scheduled physician visits, at least twenty-four (24) hours in advance may also be required to confirm scheduled trips the morning of or twenty-four (24) hours in advance.

4. Passengers with a frequent pattern of no-shows will receive written notice from the State's transportation management authority that they will be subject to a change in their transportation benefit. (See § 2.18 of this Part, "Complaint Process for Medicaid Beneficiaries and Persons Using the Non-Medicaid Elderly Transportation Program and TANF recipients").

2.10 Physician's/Clinician's Attestation and/or Documentation

All NEMT transportation requests that require an attestation and/or written statement by the recommending physician/clinician must include the specific reason/rationale why NEMT is required based upon a client's functional ability and not only upon diagnosis.

2.11 Transportation Provider Participation Guidelines

A. To participate in the NEMT Program, a transportation provider must enter into a signed agreement with the State's transportation management authority. Providers must be in compliance with all applicable State and federal statutes and regulations. All providers will be recruited and retained by the State's transportation management authority. All required provider documents must be submitted to the State's transportation management authority. All providers must meet the requirements set forth by the State's transportation management authority.

B. Drivers must treat beneficiaries with courtesy and respect.

2.11.1 Ambulance Providers:

A. Must have a license issued through the Rhode Island Department of Health (DOH);

B. License must be renewed annually;

C. Must have proof of insurance.

2.11.2 Taxi, Limited Public Motor Vehicles, and Public Motor Vehicles:

A. Must have a license issued through the Rhode Island Division of Public Utilities and Carriers (DPUC) validating proof of authority to engage granted by the DPUC. R.I. Gen. Laws Chapter 39-14 (Taxicabs and Limited Public Motor Vehicles) and R.I. Gen. Laws Chapter 39-14.1 (Public Motor Vehicles).

1. Taxis and Limited Public Motor Vehicles – Public Certificate for Convenience and Necessity

2. Public Motor Vehicles – Certificate of Operating Authority.

B. Providers are required to maintain and ensure drivers have a valid Hackney License (Blue Card).

C. All licenses must be renewed annually through the Division of Public Utilities and Carriers (DPUC).

2.11.3 Ride-Share Vehicles

Drivers and vehicles must be in compliance with ride-share company standards.

2.11.4 Personal Vehicles

A. Vehicles used to provide transportation to a beneficiary must be in good condition, safe for transport, and have current and valid:

1. Registration

2. State Inspection and

3. Proof of Insurance.

B. The driver must have a valid, unrestricted driver's license and the driver must have completed any and all training required by the transportation management authority.

2.12 Recertification Process

A. Ambulance providers shall be recertified annually by the Rhode Island Department of Health.

B. Taxi and Public Motor Vehicle Carriers and providers shall be required to forward a copy of their license or recertification with the DPUC to the State's transportation management authority within thirty (30) days of renewal to avoid interruption of program enrollment.

C. Ride share companies must also provide a copy of their annual recertification permit as a Transportation Network Company to the State's transportation management authority to avoid interruption in program enrollment.

2.13 Claims Billing Guidelines

A. NEMT: The State's transportation management authority is responsible for claims and billing for NEMT.

B. Emergency Transportation: Providers will bill the health plans for emergency transportation provided to Medicaid managed care beneficiaries. Providers will bill the Medicaid fee-for-service program for emergency transportation provided to Medicaid beneficiaries enrolled in the State's fee-for-service delivery system.

2.13.1 Medicare/Medicaid Crossover Claims

A. Emergency Transportation

1. Medicare is the primary payer for emergency transportation. The Medicaid FFS Program will not make any additional payment on claims where the Medicare payment is equal to or more than the Medicaid allowable amount.

2. Payment of cross-over claims for Medicaid managed care recipients is handled and directed by the managed care plans.

B. Non-Emergency Transportation

1. Certain forms of non-emergency transportation may be covered by Medicare. This may include basic life support and advanced life support (both of which are provided by ambulance) as well as transportation provided to/from hospitals and dialysis centers. The transportation management authority may be responsible for payment of Medicaid-covered NEMT services that were denied by Medicare, subject to prior approval and verification by the broker.

2.13.2 Patient Liability

A. The NEMT payment is considered payment in full. The transportation provider is not permitted to seek further payment from the Medicaid beneficiary in excess of any payment received from the State's transportation management authority.

B. Emergency Transportation: Transportation providers are not permitted to seek further payment from the participant in excess of any payment received for emergency transportation from either the health plan or the Medicaid FFS Program.

2.14 Non-Medicaid Elderly Transportation Program

A. The Non-Medicaid Elderly Transportation Program (ETP) is for individuals age 60 years and older who are not Medicaid eligible and who are not getting transportation from the RIPTA RIde Program or from the Americans with Disabilities Act (ADA) Program.

B. Transportation funds available for this Program are specifically allocated for services to be provided for Rhode Island residents sixty (60) years of age and older.

C. The ETP provides transportation to and from medical appointments, adult day care, meal sites, dialysis/cancer treatment and the "INSIGHT Program."

D. The program requires a co-payment for each trip segment. The co-payment amount is determined by EOHHS. The co-payment is collected and retained by the transportation driver. Medicaid and "Costs Not Otherwise Matchable" ("CNOM")-eligible individuals are exempt from this co-pay for transportation in Priorities #1 - #4 in § 2.15 of this Part (below).

E. The ETP provides safe, quality transportation services to qualified elderly individuals. Emphasis is placed on priority categories of transportation services in relation to existing state funding, vehicle and passenger safety and sensitivity to the needs and concerns of elderly clients, and consistent assignment of preferred transportation providers to the maximum extent possible.

F. Eligible participants must be legal residents of the State of Rhode Island. As a condition of eligibility for transportation services, participants must provide the information noted below to the transportation management authority. This may include, but is not limited to:

1. Date of birth;

2. Proof of residency, including but not limited to, valid Rhode Island driver's license and/or Rhode Island state identification card issued by the Rhode Island Division of Motor Vehicles; voter identification card; current utility bill for a residence within Rhode Island in the name of the individual requesting transportation services;

3. Social Security number;

4. Medical documentation as requested by the State's transportation management authority.

2.15 Non-Medicaid Elderly Transportation Program – Specific Services

The following transportation services may be provided to Rhode Island elders by the State's transportation management authority based on the following prioritization. Service provision is contingent upon available state funding.

2.15.1 Special Medical Care (Priority 1)

Special medical transportation includes transportation for the purpose of kidney dialysis or cancer treatments. Names of clients to be transported are to be provided to the State's transportation management authority by the medical treatment facility, family, friends, or

the client themselves. The State reserves the right to limit special medical transportation based on funding constraints or other programmatic requirements.

2.15.2 Adult Day Care (Priority 2)

This category includes transport to and from adult day care centers that are licensed by the Department of Health (DOH). Residences of clients shall be verified by the adult day care center and provided to the State's transportation management authority. The State reserves the right to limit transportation to adult day care centers based on funding constraints or other programmatic requirements.

2.15.3 General Medical Care (Priority 3)

This category includes transportation for any medical/health services that are part of a total patient plan of care supervised by a health care professional. Trips eligible under this service category include visits to physicians' offices and dental offices as well as all trips for tests and/or treatments ordered by a health care professional as part of a treatment plan. The State reserves the right to limit general medical transportation based on funding constraints or other programmatic requirements.

2.15.4 INSIGHT (Priority 4)

A. This category includes transport to and from INSIGHT, at their INSIGHT service location(s). Riders must be sixty-five (65) years of age or over, have a sight impaired condition and/or presently registered with the INSIGHT agency.

B. Transportation shall be at the discretion of the State and available during the same days and hours as general medical trips. Trip requests must be forwarded to the State's transportation management authority at least forty-eight (48) hours in advance. The State reserves the right to limit transportation to INSIGHT based on funding constraints or other programmatic requirements.

2.15.5 Senior Nutrition Transportation (Priority 5)

This category includes transport to and from congregate meal sites for the elderly. The senior nutrition project shall be responsible for securing names and addresses of individuals to be transported. This information shall be forwarded to the State's transportation management authority for scheduling. The nutrition site shall verify residence of all individuals in the geographic area. The State reserves the right to limit transportation to specific meal sites based on funding constraints or other programmatic requirements.

2.16 Non-Medicaid Elderly Transportation Program Service Provision Guidelines

2.16.1 Limitation on Transportation

Subject to state and federal law, EOHHS reserves the right to limit, restrict, or terminate the availability of transportation due to funding constraints, programmatic requirements, service availability, weather, etc. (This provision applies to clients of the ETP only).

2.16.2 Service Models

A. Curb-to-curb

B. Door-to-door

C. Wheelchair van: Wheelchair dependent beneficiaries must provide their own wheelchair. Beneficiaries must request this service at the time of reservation to the State's transportation management authority. Transportation providers are not permitted to enter the client's residence or the provider's office. Beneficiaries who will require additional assistance in leaving their destination or upon arrival at their medical appointment may bring an escort with them. Beneficiaries must inform the transportation management authority when they reserve transportation that an escort will accompany them.

2.16.3 Transport to Nearest Sites

A. Transportation to kidney dialysis, cancer treatments and general medical trips shall be to the facility closest to the client's home, unless transportation to another facility is more appropriate. The facility closest to the client's home may be in a bordering town listed in § 2.20 of this Part.

B. Transportation to adult day care facilities and meal sites shall be to the facility closest to the client's home unless transportation to another center is more appropriate. This is also subject to the availability of transportation services to that center. The facility closest to the client's home may be in a bordering town listed in § 2.20 of this Part.

2.16.4 Days and Hours of Service

Service days shall typically include Monday-Friday. Trips may also be scheduled on weekends and holidays when medically necessary. Trips for senior nutrition transportation (Priority 5) must occur between 10:00 a.m. – 2:00 p.m.

2.16.5 Passenger Cancellations

A. Passengers must make every effort to keep their scheduled trip appointments. If unable to keep an appointment, notification must be provided to the State's transportation management authority at least twenty-four (24) hours prior to the scheduled trip.

B. If a medical appointment is cancelled the same day, or there are other unforeseen circumstances, the beneficiary should contact the State's transportation management authority as soon as possible.

2.16.6 Passenger No-Shows

A. Standing Orders

1. Passengers who frequently (more than three (3) instances per month) do not cancel their regularly scheduled trip appointments at least twenty-four (24) hours in advance may be required to schedule each trip separately at least two (2) days in advance, and will no longer be eligible for "standing order" pick-ups.

2. After a sixty (60) day period, passengers may request reinstatement of eligibility for standing order and scheduled ride pick-ups without being required to confirm such trips in advance. Requests will be subject to EOHHS approval.

B. Passengers who frequently (more than three (3) instances per month) do not cancel other scheduled trips, such as separate physician visits, at least twenty-four (24) hours in advance will be required to confirm scheduled trips the morning of or twenty-four (24) hours in advance.

C. Passengers with a frequent pattern of no-shows will receive written notice from the State's transportation management authority that they will be subject to a change in their transportation benefit. Individuals will receive written notice on how to appeal this determination. (See § 2.18 of this Part, "Complaint Process for Medicaid Beneficiaries and Persons Using the Non-Medicaid Elderly Transportation Program and TANF recipients").

2.17 Transportation for Recipients of Temporary Assistance to Needy Families (TANF)

A. Recipients of the State's Temporary Assistance to Needy Families (TANF) Program are eligible to receive a monthly bus pass. To obtain a monthly bus pass, TANF recipients must call the State's transportation management authority to request a pass.

B. Bus passes will be mailed to the recipient following the request.

2.18 Complaint Process for Medicaid Beneficiaries and Persons Using the Non-Medicaid Elderly Transportation Program and TANF Recipients

A. Individuals may file a complaint as follows:

1. Passengers or their family members may submit a formal written or verbal complaint to the State's transportation management authority. Contact information is available at www.eohhs.ri.gov.

2. The State's transportation management authority will attempt to resolve the complaint with the individual and/or his/her family.

3. In the event transportation benefits are terminated or substantially altered, after due notice, and the complainant wishes to pursue his/her concerns further, a written complaint shall be forwarded to the State for a fair hearing. State fair hearings shall be conducted in accordance with the provisions of Part 10-05-2 of

this Title, Appeals Process and Procedures for EOHHS Agencies and Programs, promulgated by EOHHS and available on the Secretary of State's website.

4. In the event ETP transportation benefits are terminated or altered due to a lack of Program funding, formal appeal rights to a fair hearing shall not be available.

2.19 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.

2.20 Border Communities

A. Border Communities include cities and town that border Rhode Island and are considered for the purpose of the Rhode Island Medical Assistance Program, in-state providers. Out-of-state service restrictions and prior authorization requirements are not imposed on providers in the following communities:

Connecticut	Massachusetts
Danielson	Attleboro
Groton	Bellingham
Moosup	Blackstone
Mystic	Dartmouth
New London	Fall River
North Stonington	Foxboro
Pawcatuck	Milford
Putnam	New Bedford
Stonington	North Attleboro
Thompson	North Dartmouth
Waterford	Rehoboth
	Seekonk
	Somerset

Connecticut	Massachusetts
	South Attleboro
	Swansea
	Taunton
	Uxbridge
	Webster
	Westport
	Whitinsville

Chapter 20 - Medicaid Payments and Providers

Subchapter 00 - N/A

Medicaid Payments for Out-of-State Care (210-RICR-20-00-3)

3.1 Legal authority and purpose

A. Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) provides the legal authority for the Rhode Island Medicaid Program. The Medicaid Program also operates under a waiver granted by the Secretary of Health and Human Services pursuant to Section 1115 of the Social Security Act (42 U.S.C. § 1315). Additionally, R.I. Gen. Laws Chapters 40-6, 40-8, and R.I. Gen. Laws § 40-8-31 serve as the enabling statutes for this regulation.

B. The purpose of this rule is to describe the respective roles and responsibilities of EOHHS and Medicaid beneficiaries as it relates to receiving Medicaid services outside of Rhode Island.

3.2 Definitions

A. As used herein, the following terms shall be construed as follows:

1. “Executive Office of Health and Human Services" or "EOHHS” means the state agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 within the executive branch of state government and serves as the principal agency for the purposes of managing the Departments of Children, Youth, and Families (DCYF); Health (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The EOHHS is designated as the “single state agency,” authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

2. “Temporarily absent” means time spent away from one’s usual living arrangements. The length of time an absence is considered temporary varies based upon the reason for the absence, such as hospitalization, vacation, or employment. During temporary absences, the responsibility to provide Medicaid benefits does not transfer between states.

3.3 REQUIREMENT OF PRIOR AUTHORIZATION

A. Payment for out-of-state medical services that are provided to eligible Medicaid beneficiaries living within Rhode Island requires prior authorization from the Executive Office of Health and Human Services (EOHHS).

B. The following conditions must be met to obtain prior authorization for out-of-state medical services:

1. If a Medicaid beneficiary requires services from an out-of-state hospital or physician, the beneficiary's attending physician must submit written medical justification to EOHHS;

2. The medical services that are required and being requested must not be available within Rhode Island.

C. Out-of-state medical services require prior authorization. Only those services that are contained within the Rhode Island Medicaid scope of services will be reimbursed.

3.4 Exceptions to the Requirement for Prior Authorization

A. The following provisions are exceptions to the requirement for prior authorization:

1. Emergency medical treatment and hospital services needed because the beneficiary's health would be endangered if travel back to Rhode Island was required;

2. Treatment was provided by hospitals and practitioners located in one of the border communities listed in § 3.6 of this Part where it is the general practice for residents to use medical resources in these communities;

3. Medical and hospital treatment provided to foster children residing with families located outside Rhode Island or in out-of-state residential treatment centers.

3.5 Services Rendered to Temporarily Absent Beneficiaries

A. Payment for medical care provided to eligible residents of Rhode Island who are temporarily absent from the state is made under certain circumstances.

B. Temporarily absent includes visiting, traveling or residing temporarily in another state without intending to become a permanent resident of the alternate state. Medicaid payment is authorized only in the following circumstances:

1. An emergency arises from an accident or illness; or

2. The health of the individual would be endangered if the care and services were postponed until the individual returned to Rhode Island; or

3. The health of the individual would be endangered if s/he undertook travel to return to Rhode Island.

C. When EOHHS receives a claim for out-of-state medical care not authorized in advance that was rendered to a Medicaid beneficiary temporarily absent from the state, the EOHHS contacts the Medicaid beneficiary to determine residency plans.

1. If the Medicaid beneficiary indicates s/he is planning to return to the state, written notification of this is required to be sent to EOHHS;

2. If the Medicaid beneficiary indicates in writing that s/he plans to reside permanently outside Rhode Island, Medicaid benefits are terminated at the end of the month following the month in which the notification of intent to reside outside Rhode Island is received.

3.6 Border Communities

A. Border Communities include cities and town that border Rhode Island and are considered for the purpose of the Rhode Island Medicaid Program, in-state providers. Out-of-state service restrictions and prior authorization requirements are not imposed on providers in the following communities:

Connecticut	Massachusetts
Danielson	Attleboro
Groton	Bellingham
Moosup	Blackstone
Mystic	Dartmouth
New London	Fall River
North Stonington	Foxboro
Pawcatuck	Milford
Putnam	New Bedford
Stonington	North Attleboro
Thompson	North Dartmouth
Waterford	Rehoboth
	Seekonk

Connecticut	Massachusetts
	Somerset
	South Attleboro
	Swansea
	Taunton
	Uxbridge
	Webster
	Westport
	Whitinsville

3.7 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.

Chapter 30 - Medicaid for Children, Families, and Affordable Care Act (ACA) Adults

Subchapter 00 - Affordable Coverage Groups

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

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.

Chapter 30 - Medicaid for Children, Families, and Affordable Care Act (ACA) Adults

Subchapter 00 - Affordable Coverage Groups

Medicaid Application and Renewal Processes 210-RICR-30-00-3

3.1 Application Process for Medicaid Affordable Coverage: No Wrong Door

3.1.1 Scope, Purpose, and legal authority

A. One of the central goals of the federal Affordable Coverage Act (hereinafter the ACA) of 2010 (Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq*.) was to improve access to and the availability of affordable health coverage. Toward this end, the ACA mandated that the states reform the Medicaid application and renewal system to make it easier for consumers to navigate and gain access to and retain affordable health care coverage.

B. The purpose of this rule is to set forth the application and renewal processes for members of the Medicaid Affordable Care Coverage (MACC) groups subject to MAGI-based income eligibility determinations. The rule also sets forth the respective roles and responsibilities of the EOHHS, its eligibility agents, and applicants/ beneficiaries. In addition, the rule establishes the application and renewal processes for children in the Integrated Health Care Coverage (IHCC) groups who are exempt from MAGI determinations under federal law and regulations and, therefore, the Medicaid State Plan because their eligibility is tied to participation in other publicly funded programs including federal Supplemental Security Income (SSI), and the programs for children and youth at-risk or in the custody of the Rhode Island Department of Children, Youth and Families (DCYF).

C. This Part is promulgated pursuant to:

1. Federal authorities as follows:

    a. Federal Laws -Title IVE, Title XIX, Title XXI of the U.S. Social Security Act and ACA.

    b. Federal Regulations - 42 C.F.R. §§ 435.603; 435.902 through 910; 435.916; 435.1025

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

2. State authorities - R.I. Gen. Laws Chapters 40-6, 40-8, 42-7.2.

3.1.2 Definitions

A. As used herein, the terms below have the meanings described:

1. “Application access points” means the various contact points where consumers or their representatives can access the application process either directly through the State’s integrated eligibility system’s consumer portal (on-line) or with the assistance of EOHHS, the Department of Human Services (DHS), or HealthSource RI (HSRI) representatives, or an application entity designated by the state for such purposes (in-person, by telephone or a mail-in application).

2. “Application entity” means an organization or firm acting on a State agency’s behalf that provides applicants for affordable coverage with an application access point including the EOHHS, the DHS, the HealthSource RI (HSRI) and any organizations designated for such purposes that maintain a staff of certified navigators or in-person assistors.

3. “Enrollee” means a Medicaid member or beneficiary who is enrolled in a Medicaid managed care plan.

4. “Integrated health and human services eligibility system" or "IES” means the state's eligibility system that enables applicants, through a single application, to be considered for several human service programs simultaneously, including affordable health coverage and human 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 as set forth in Part 1 of this Subchapter.

6. “MAGI standard” means the method for evaluating Medicaid income eligibility using the modified adjusted gross income (MAGI) standard established under the ACA. The MAGI is the standard for determining income eligibility for all MACC groups.

7. “Modified passive renewal” means a method for determining continuing eligibility using electronic data sources and information provided by beneficiaries. This method is only used when the eligibility factors subject to change cannot be evaluated fully by the available electronic data sources or information in the beneficiary’s account. This process may also be used when there is insufficient information to determine whether a beneficiary who is losing coverage due to a change in an eligibility factor is eligible in another coverage group, such as when a MACC adult is about to turn sixty-five (65) and must be evaluated using the SSI methodology specified in Chapter 40 of this Title.

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

9. “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, the term refers to the children and youth who are eligible for Medicaid based on their participation in another publicly funded program and/or by federal law, including infants born to Medicaid eligible mothers, recipients of Supplemental Security Income (SSI) cash assistance under age twenty-one (21), and children and youth who are, or in some instances were, in the care and/or custody of the Rhode Island Department of Children, Youth and Families (DCYF).

10. “Passive or *ex parte* renewal” means a method for determining continuing eligibility that uses electronic data sources to confirm ongoing eligibility without information or action on the part of a beneficiary, unless certain types of discrepancies are detected. The State may require members to resolve discrepancies in pre-populated forms or in on-line accounts.

3.1.3 Application Access Points

A. Under the State’s “No Wrong Door Policy”, consumers must have easy access to a choice of application access points. New applicants for affordable coverage may access the eligibility system and complete the application process through application entities that have been designated for this purpose and on their own or with assistance, if necessary, through any of the following access points:

1. On-line Consumer Portal -- Applicants have the option of accessing the eligibility system and applying on-line using a self-service portal through links on the EOHHS (eohhs.ri.gov) and DHS (dhs.ri.gov) websites or directly through HSRI (HealthSourceRI.com). The information applicants provide is entered directly into the IES and is processed electronically in real-time.

2. In-person or by telephone - Applicants may apply in-person at DHS field offices with the assistance of an agency representative or on their own using kiosks established for this purpose. The Contact Center also provides access to walk-in applicants and consumers who make contact by telephone. If an applicant is unwilling or unable to apply on-line, an agency or Contact Center representative must enter the information into the IES on the applicant’s behalf.

3. On-paper - Applicants may submit paper applications in-person or by U.S. Mail, e-mail transmissions, and facsimile transmissions to the address specified on the application. Paper applications are available on-line, through the U.S. Mail upon written request or telephone request (1-855-840-4774 or 1-888-657-3173 (TTY), or in-person at any DHS field office or the Contact Center. Upon receipt, an agency or Contact Center representative must enter the information provided on the paper application directly into the eligibility system portal and submit the application for a determination on the applicant’s behalf.

4. Application Entities - Applicants may access the eligibility system with the assistance of application entities that provide navigators or other in-person assisters (IPAs). Members of these entities assist applicants in completing paper applications or applying through the on-line portal. A list of these application entities is available from the Contact Center or on-line by visiting the EOHHS website (www.eohhs.ri.gov).

3.1.4 Completing and Submitting the Application

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

1. Account Creation -- To initiate the application process, the applicant, agency or Contact Center representative, or application entity assisting the applicant, must create a login and establish an account in the eligibility system.

a. The applicant must provide personally identifiable information for the purpose of creating an on-line account and establishing identity during this process. Verification of this information is automated through the federal data hub (see MCAR section 1308, "Verification/Datahub"). Documentation verifying identity may be required if the automated verification process is unsuccessful. Acceptable forms of identity proof include, but are not limited to, a driver's license, school registration, voter registration card. Documents may be submitted via mail, fax, on-line upload, to a DHS Office, or the HSRI. (See MCAR section 1308, "Verification/Datahub" for additional information).

b. Once identity is verified, the Medicaid agency must conduct account matches in accordance with MCAR section 1308 to determine whether the applicant or members of the applicant's household have other accounts or are currently receiving benefits. It is the State's responsibility to resolve account matching issues and notify the applicant of any necessary actions.

2. Account Duration - An application account is open for a period of ninety (90) days. Applicants must restart the process if they have not completed and submitted an application within that period.

a. Applications may be started at any time. Once started, progress can be saved at any point and the application returned to at a later time. Incomplete applications not submitted within ninety (90) days are automatically deleted in the eligibility system.

b. Eligibility determinations for Medicaid. Determinations must be made within thirty (30) days from the date the completed application is received. The application remains open after that period if the State or its eligibility designee (DHS) or agents (application entities) are responsible for delays in the eligibility determination.

c. Temporary eligibility period. If there are discrepancies between an applicant's attestations and electronic data matches on immigration eligibility factors, eligibility is granted for a period of no more than ninety (90) days. The application remains open during this period to allow the applicant sufficient time to obtain necessary documentation. (See MCAR §§ 1308.09 and 1308.10, "Verification/ Datahub").

3. Application Materials - Applicants must answer all the required questions for each member of their household. Application questions focus on the need for all types of affordable coverage and specific Medicaid eligibility criteria related to the applicable MACC group. In general, applicants will be able to provide answers to the application questions with information used when filing federal tax forms and/or documents commonly used for identification and income verification purposes. When applying through the web portal on-line, electronic verification through data matches will limit the applicant's need to refer to these materials. However, when using a paper application, access to these materials may be necessary. Materials that may be of assistance in such instances include, but are not limited to:

a. Federal tax filing status

b. Household/family size

c. Social Security numbers

d. Birth dates

e. Passport or other immigration numbers

f. Federal tax returns

g. Information about any health coverage available to you or your family, including any information you have about the health insurance your current employer offers even if you are not covered by your employer's insurance plan

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

i. 1099 forms, if you are self-employed.

4. Application Completeness - Before a determination of eligibility is made, all questions on the application must be completed. Applicants must be informed and offered the opportunity to provide any additional documentation or explanations necessary to proceed to the determination of eligibility. Such information will be provided to applicants immediately through a notification from the eligibility system when using the self-service portal. The agency or HSRI, or application entity entering the information into the eligibility system on the applicant's

behalf, must provide this information to the applicant immediately once it becomes available, by letter or phone if the applicant is not present. However, the application filing date is not established until the completed form is submitted.

5. Voluntary Withdrawal. An applicant may request that an application for Medicaid health coverage be withdrawn at any time either through their secure on-line account or by submitting the request in writing via the U.S. Mail or fax to the EOHHS or DHS agency or a HSRI representative. Withdrawal of the application may also be made by telephone to the HSRI. The State sends a notice to the applicant verifying the time and date of the voluntary withdrawal and indicating that the applicant may reapply at any time.

3.1.5 Attestation of Application Information

A. All questions on the application must be answered in a truthful and accurate manner. Every applicant must self-attest to the truthfulness and accuracy of the question responses and documentation submitted by providing an electronic signature under penalty of perjury.

1. Electronic Matches - Federal and State Data Sources: The eligibility system verifies attestations through electronic data matches to the fullest extent feasible with external sources such as the U.S. Social Security Administration (SSA) and Internal Revenue Service (IRS) and RI agencies such as the Division of Motor Vehicles (DMV), the Office of Vital Statistics and the Department of Labor and Training (DLT). The eligibility factors subject to verification are specified in the MCAR section 1305, "Eligibility Requirements"; the verification process is located in MCAR section 1308, "Verification/Datahub."

2. Attestation -- Before an application can be submitted, the applicant, or the person/entity acting on the applicant's behalf, must authenticate by signature that the information provided is genuine, correct, and true. When applying on-line, the attestation is conducted electronically. An agency or HSRI representative or an authorized application entity must verify that the application was signed (mail application), a voice signature was obtained (telephone application), or that the applicant signed a declaration in-person. The signature provided by the applicant in these instances is an attestation to both the applicant's identity and the truthfulness and accuracy of the information on the application. There are circumstances when an applicant's attestations and verification data matches show discrepancies. (See MCAR section 1308, "Verification/ Datahub" for the provisions governing reconciliation of such differences).

3.1.6 Privacy of Application Information

Application information must only be used to determine eligibility and what types of coverage a person is qualified to receive. Accordingly, the State, HSRI, or application entity must maintain the privacy and confidentiality of all application information and in

the manner required by applicable federal and state laws and regulations and as provided in Part 10-05-1 of this Title.

3.1.7 Notice of Determination of Eligibility

A. Once an application is completed and the required verifications are performed, eligibility for Medicaid and other forms of affordable coverage is made for each member of the household. (For information on other forms of affordable coverage, see www.HealthSourceRI.com or call HSRI at 1-855-840-4774).

B. Household members determined Medicaid-eligible may enroll immediately in the health plan of choice. A formal notice will be generated after the determination indicating which household members are eligible for Medicaid or other forms of affordable coverage, the legal basis for the determination of eligibility, and the plan in which each household member is enrolled, if applicable. The notice will be sent via the applicant's secure on-line account if opting to receive agency communications in such a manner or by mail in a reasonable time period. A "reasonable time" period usually will not exceed ten (10) business days, but in no instance will it extend beyond the 30-day application period.

C. The notice must also advise the applicant of the right to appeal and request a hearing, in accordance with MCAR section 0100, "Complaints and Appeals."

3.1.8 Agency and Applicant Roles and Responsibilities

A. The State and applicants have shared and distinct responsibilities in the application process.

1. Medicaid agency -- Under current state and federal laws, the Medicaid State Agency is required to:

a. Assist applicants in completing all necessary forms.

b. Provide applicants with an interpreter or translator services upon request.

c. Assure all information applicants provide is kept confidential unless otherwise authorized to share with other state and federal agencies for the purposes of verification and enrollment.

d. Make timely determinations of eligibility in accordance with applicable laws and regulations.

e. Accept appeals and hold hearings on agency actions related to eligibility decisions in accordance with MCAR Section 0110, "Complaints and Appeals."

f. Provide a mechanism for beneficiaries to voluntarily withdraw eligibility for Medicaid health coverage at any time by submitting a written request via the U.S. Mail or fax to the EOHHS or DHS agency or an HSRI representative.

2. Applicant Rights and Responsibilities -- All applicants have the following:

a. Applicant Rights --The right to obtain help in completing forms; to an interpreter or translator, upon request; to be treated free from discrimination on the basis of race, color, national origin, sex, gender identity or sexual orientation, age or disability; to have personal information remain confidential; and to file an appeal and request a hearing on eligibility actions.

b. Applicant Responsibilities -- The responsibility to:

(1) Disclose certain information including Social Security numbers and proof necessary to determine eligibility;

(2) Report changes in income, family size and other application information as soon as possible; and

(3) Sign the application and thereby agree to comply with any applicable laws related to the type of eligibility requested and the coverage received.

3.2 Renewal of Eligibility for Medicaid Affordable Care Coverage Groups

3.2.1 Scope and Purpose

All MACC group members are subject to MAGI-based renewals, focusing on the eligibility factors subject to change. Such factors include changes in income, household composition or family size (due to death, marital status, birth or adoption of child), and/or State residency. Disenrollments for any reason that are followed by requests for eligibility reinstatements are also subject to this process for members of the MACC groups.

3.2.2 Responsibilities of the State

A. The State is responsible to ensure that the Medicaid renewal process occurs once every twelve (12) months for all MACC group members. Towards this end, the State must meet the following requirements:

1. Basis of Renewal - The eligibility renewal must be based on information already available to the State to the full extent feasible. Accordingly, the State must use information about the Medicaid member from reliable sources including, but not limited to, the member’s automated eligibility account, current paper

records, or data bases that may be accessed through the federal data hub or the State's own affordable care coverage eligibility system.

2. Restrictions - The State must not request or use information when conducting renewals pertaining to: eligibility factors that are not subject to change or concern matters that are not relevant to continuation of Medicaid eligibility. Eligibility factors subject to change include income, household or family size, State residency and certain immigration statuses. Factors that are not subject to change include, but are not limited to, native born or naturalized U.S. citizenship, date of birth, and Social Security Number.

3. Renewal Strategy - The State utilizes a passive "ex parte" renewal process for all MACC group members when determining continuing eligibility and whether a beneficiary who is losing coverage due to a change in an eligibility factor qualifies for Medicaid in another coverage group to the full extent feasible. This renewal method confirms eligibility factors subject to change through electronic data sources and only requires action on the part of the beneficiary if certain discrepancies are detected by the State or self-reported. The State will use both active and passive renewal methods until all MACC group members have been subject to a MAGI-based income eligibility determination at least once. Accordingly, the State will conduct renewals as follows:

a. Initial review. The State redetermines eligibility at least sixty (60) days before the renewal date using information known to the IES and from various data sources and provides notice to the beneficiary indicating the results of this review. The notice contains the information that served as the basis for this eligibility review and indicates one of the following:

(1) Passive Ex Parte Renewal -- Medicaid eligibility has been renewed "ex parte" and no further action on the part of the beneficiary is required unless, upon reviewing the information in the notice, the beneficiary identifies an error or a change in an eligibility factor subject to change that must be reported to the State; or

(2) Modified Passive Renewal --Medicaid eligibility has not been renewed due to missing information or a discrepancy between sources of information related to an eligibility factor subject to change. In such instances, the notice contains an additional documentation request (ADR) specifying the type of information that must be submitted for the renewal of eligibility to proceed.

b. Renewal decision. If the beneficiary is not required to take any action and does not find cause to self-report a change, Medicaid eligibility is continued automatically for another year, effective on the renewal date. However, in order to be considered in this final renewal decision, change self-reports and ADR responses must submitted at least thirty (30) days

from the date of the renewal notice. The State redetermines eligibility based on this information. If the beneficiary receives an ADR and does not take the action required, this redetermination is based solely on the information known to the IES through self-attestations and applicable data sources. A formal notice is issued with the State's final renewal decision if eligibility is discontinued on this basis at least fifteen (15) days prior to the eligibility continuation or termination date. Information received by the State at any time prior to the eligibility termination date is considered. However, if the information is submitted after the tenth day of the renewal month, a change from managed care to fee-for-service service delivery may result.

c. Reinstatement. A reinstatement of Medicaid eligibility is permitted without a full reapplication, in instances in which a beneficiary takes the actions required to resolve a discrepancy or information gap in the ninety (90) day period after eligibility is terminated.

4. Consent - The State must obtain the consent of the Medicaid member to retrieve and verify electronically information related to eligibility factors subject to change including any federal tax information required to review income eligibility. Such consent is obtained during the initial application for Medicaid eligibility when the Medicaid member signs the application, under penalty of perjury.

5. Enrollment - A Medicaid member whose eligibility has been continued through the annual renewal process must remain in the same Medicaid health plan unless the renewal occurs during an open enrollment period. If an open enrollment process is not underway at the time of renewal, the provisions set forth in Subchapter 05 Part 2 of this Chapter prevail.

6. Access - The State must ensure that any application or supplemental forms required for renewal are accessible to persons who have limited proficiency in English or who have a disability.

3.2.3 Responsibilities of Medicaid Members

A. Medicaid members must ensure that the State has access to accurate and complete information about any eligibility factors subject to change at the time of the annual renewal. Accordingly:

1. Consent - At the time of the initial application or first MAGI-based renewal, Medicaid members must provide the State with consent to retrieve and review any information not currently on record pertaining to the eligibility factors subject to change through electronic data matches conducted through the State's affordable coverage eligibility system. Once such consent is provided, the State may retrieve and review such information when conducting all subsequent annual renewals.

2. Duty to Report -- Medicaid members are required to report changes in eligibility factors to the Medicaid agency within ten (10) days from the date the change takes effect. Self-reports are permitted through the eligibility system on-line portal. Medicaid members also may report such changes in person, via fax, by mail, or telephone with the assistance of HSRI, DHS agency representative, or Navigator. Failure to report in a timely manner, as noted above, may result in the discontinuation of Medicaid eligibility.

3. Cooperation - Medicaid members must provide any documentation that otherwise cannot be obtained related to any eligibility factors subject to change when requested by the State. The information must be provided within the timeframe specified by the State in the notice to the Medicaid member stating the basis for making the agency's request.

4. Voluntary Termination -- A Medicaid member may request to be disenrolled from a Medicaid health plan or to terminate Medicaid eligibility at any time. Disenrollment results in the termination of Medicaid eligibility.

5. Reliable Information - Medicaid members must sign under the penalty of perjury that all information provided to the Medicaid agency at the time of application and any annual renewals thereafter is accurate and truthful.

3.3 Information

3.3.1 For Further Information or to Obtain Assistance

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

1. www.eohhs.ri.gov

2. www.dhs.ri.gov

3. www.HealthSourceRI.com

B. Applicants may also apply in person at one of the DHS offices or by U.S. Mail. Request an application by calling 1-855-840-4774 or TTY 1-888-657-3173.

C. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-840-HSRI (4774).

3.4 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.

Chapter 30 - Medicaid for Children, Families, and Affordable Care Act (ACA) Adults

Subchapter 00 - Affordable Coverage Groups

Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals (210-RICR-30-00-4)

4.1 Overview and Statutory Authority

A. The goal of the federal Affordable Care Act (ACA) of 2010 is to improve access to high quality health insurance coverage for people of all ages and income levels. In keeping with this purpose, the ACA established a presumptive eligibility program for certain individuals and families in the newly reconfigured Medicaid Affordable Care Coverage (MACC) groups. The MACC groups in Rhode Island are described in "Medicaid Code of Administrative Rules, Section 1301, 'Medicaid Affordable Care Coverage Groups'".

B. Federal regulations governing the program at 42 C.F.R. § 435.1110 authorize the states to provide Medicaid for a limited period of time to individuals who are determined by a "qualified hospital", on the basis of preliminary information, to be presumptively eligible for Medicaid. This initial determination is made by the hospital on the basis of the characteristics for MACC group eligibility. The states have the discretion under these provisions to tailor presumptive eligibility requirements program within certain parameters to meet their own unique needs.

4.2 Scope and Purpose of Hospital Presumptive Eligibility Program for Medicaid

A. The State of Rhode Island had determined that presumptive eligibility will be available to individuals in the MACC groups who qualify for Medicaid-funded affordable coverage. For all other individuals with MACC-like characteristics, presumptive eligibility must be determined by a qualified hospital, licensed in Rhode Island, and is only available in certain circumstances contingent upon preliminary information supplied by the individual. Further, presumptive eligibility is only available on a temporary basis - until the last day of the month following the initial determination of presumptive eligibility or the date full eligibility is determined, whichever comes first.

1. Exclusions: Individuals in the MACC groups who are eligible for affordable coverage funded through the Children's Health Insurance Program (CHIP) under Title XXI of the U.S. Social Security Act are excluded from presumptive eligibility. CHIP-funded beneficiaries excluded from HPE are as follows:

a. All lawfully present non-citizen children while subject to the federal five (5) year ban;

b. Children up to age 19 with income from 133% to 261% of the FPL;

c. All non-qualified non-citizen pregnant women with income up to 253% of the FPL; and

d. Pregnant women with income from 185% to 253% of the FPL.

2. Implementation - Effective January 27, 2014, the State will be making presumptive eligibility available to individuals who have been determined by a qualified hospital to meet the characteristics of one of the MACC groups identified in "Medicaid Code of Administrative Rules, Section 1301, 'Medicaid Affordable Care Coverage Groups'" (and as below) eligible for Medicaid-funded affordable coverage under Title XIX, with the exception of the exclusions noted above.

3. Governing Provisions - The purpose of these rules is to set forth the provisions governing hospital presumptive eligibility determinations including, but are not limited to the:

a. Qualifications of applicants for Medicaid presumptive eligibility;

b. Criteria that a qualified hospital must use when making a determination of presumptive eligibility;

c. Application timelines and procedures for individuals who qualify for Medicaid coverage during the presumptive eligibility period.

4.3 Definitions

A. "Children's Health Insurance Program" or "CHIP" means the program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.

B. "Executive Office of Health and Human Services" or "EOHHS" means the designated "single state agency", authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.), to be legally responsible for the programmatic oversight, fiscal management, and administration of the Medicaid program.

C. "Hospital Presumptive Eligibility" or "HPE" means Medicaid eligibility granted on a temporary basis to a person who meets certain criteria during a defined period.

D. “Medicaid Affordable Care Coverage Groups” or “MACC Groups” means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

E. “Medicaid Code of Administrative Rules” or “MCAR” 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).

F. “Qualified Hospital” means any licensed Rhode Island hospital participating in the Medicaid program that executes a Notice of Intent to Participate in the HPE Program and a Memorandum of Understanding with EOHHS to conduct presumptive eligibility determinations, participates in training and certification sponsored by EOHHS, and remains in good standing with EOHHS protocols.

G. “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.

4.4 Populations Eligible for HPE

A. Qualified hospitals participating in the HPE Program may complete presumptive eligibility assessments for individuals who have the characteristics of members of the MACC groups funded through Title XIX. HPE excludes individuals eligible for coverage funded through CHIP and any individuals eligible for Medicaid on the basis of age, blindness or disability and/or in need of Medicaid-funded long-term services and supports.

B. Qualified hospitals are authorized to make presumptive eligibility determinations for individuals who demonstrate potential Medicaid eligibility in one of the following MACC groups, but only as specified:

1. Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) - Includes families and parents/caretakers who live with and are responsible for dependent children with income up to 133% of the FPL under the age of 18, or 19 if enrolled in school full-time.

2. Pregnant women with income up to 185% who are United States citizens or qualified non-citizens. Members of this coverage group can be of any age. Pregnant women are limited to one (1) HPE determination per pregnancy.

3. Children and Young Adults up to the age of 19 with income up to 133% of the FPL (CHIP exclusions apply).

4. Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. 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, Medicaid under any other state plan or Section 1115 waiver coverage group.

4.5 Scope of Coverage

A. Eligibility Period. The hospital presumptive eligibility period begins, and includes, the date the hospital makes the HPE determination. The hospital presumptive eligibility period ends on the date that the Medicaid agency renders a determination for full Medicaid eligibility; or the last day of the month following the month in which the hospital made the HPE determination, whichever comes first.

B. Covered Services. Individuals determined eligible for HPE, receive the same scope of State Plan and Section 1115 waiver services as members of a MACC group, except as follows:

1. All HPE beneficiaries -- No transportation services.

2. Pregnant women -- Maternity services are limited to prenatal ambulatory care only. (Birthing expenses are not covered.)

C. Service Delivery. Individuals determined to be presumptively eligible for Medicaid are enrolled in a fee-for-service plan. When full Medicaid eligibility is determined, participants will be enrolled at EOHHS' discretion in a managed care organization (MCO), as indicated in Subchapter 05 Part 2 of this Chapter.

4.6 Requirements for Hospitals

A. A hospital must meet certain requirements to be deemed qualified to participate in the HPE.

1. Participation. A qualified hospital must be licensed in RI and a participating Medicaid provider under the Rhode Island Medicaid State Plan or Section 1115 waiver. The hospital must notify EOHHS of its election to make presumptive eligibility determinations, and agree to HPE determinations in compliance with State policies/procedures and these rules.

2. Application Process: The qualified hospital must:

a. Assist individuals in completing and submitting the full application for health insurance affordability programs in Rhode Island. This assistance includes assuring that the individual understands any documentation requirements.

b. NOT require individuals assessed for HPE to verify information related to any HPE eligibility criteria/characteristic, including pregnancy.

c. Accept self-attestation of income, citizenship, and residency, as applicable, when determining eligibility.

d. Provide individuals with written notice after the HPE determination is made that includes, but is not limited to:

(1) HPE determination (i.e., approved or denied);

(2) If approved, the beginning and ending dates;

(3) If denied, the reason(s) for the denial, options for submitting a regular Medicaid application and information on how to make application.

e. The qualified hospital must utilize EOHHS-approved materials and methods in determining HPE and completing full Medicaid applications, including the EOHHS and HSRI websites and the State's single streamlined application.

3. Confidentiality. The qualified hospital must comply with all applicable State and federal laws and regulations regarding patient privacy and the confidentiality of health care communications and information.

4. Records Retention. In accordance with the provisions of the state agency's record retention policy, the qualified hospital shall maintain organized records of all HPE applications for ten (10) years from the date the last Medicaid billing was submitted to EOHHS.

5. Medicaid Agency Notification. The qualified hospital shall notify the state agency of HPE approvals, and the applicable date ranges, within five (5) business days.

6. Hospital Staff. The qualified hospital must only use employees of the hospital to assist with HPE applications. The hospital is prohibited from subcontracting HPE work to a non-hospital based company or independent contractor. In addition:

a. Each qualified hospital shall have a minimum of one (1) staff member trained and certified to perform HPE duties on each shift.

b. The hospital must affirm that all HPE personnel meet the minimum qualifications specified herein and comply with EOHHS policies and procedures for participation in the Medicaid hospital presumptive eligibility program and participate in all trainings, knowledge-based tests, and keep up-to-date on notifications with regard to HPE. The hospital

must assign one accountable individual to be the liaison with the State Medicaid Agency and its designees.

c. The qualified hospital HPE staff must assist Medicaid applicants with the completion and submission of a Medicaid application. Additionally, qualified hospital staff must provide the information specified in this subsection pertaining to the HPE decision, eligibility period, and requirement to complete a full application.

d. HPE staff must complete the requisite EOHHS training and maintain knowledge of any program changes. HPE staff training must include: in-person training; computer-based training; and proficiency testing and certification. Training and testing shall be completed at specific intervals as directed by EOHHS, but no less than annually.

(1) Assignment of Qualified Hospital Staff Online Application Credentials. Prior to assignment of online HPE administrator credentials, qualified hospital staff must complete EOHHS-approved training and provide documentation of completion of training in the format required. Proof of training also must be made available upon request by applicants.

(2) Proficiency standards. Hospital HPE staff must achieve the minimum certification testing score set forth in contractual standards established with EOHHS.

4.7 Reporting

The qualified hospital must submit monthly reports in a standardized format as defined by EOHHS. These reports must be submitted electronically by the fifth business day of the month following HPE determinations. The reports must reflect accurate measurement of the performance requirements described in § 4.8 of this Part below. In addition, the qualified hospital must prepare and submit any ad-hoc reports to EOHHS upon request.

4.8 Performance Requirements

The EOHHS requires that a qualified hospital meet certain performance standard to continue participation in the HPE. First, the qualified hospital must submit full Medicaid applications for ninety-five percent (95%) of the individuals granted HPE within five (5) calendar days from the date of the initial determination of presumptive eligibility. Second the percentage of these Medicaid applications that must be deemed fully complete by the EOHHS -- that is, contain no errors or otherwise require the State's intervention in processing -- is set forth in contractual standards between the hospital and the EOHHS. Last, the number of individuals qualifying for HPE who must be determined to be eligible for full Medicaid, as determined by the EOHHS, is also set forth in the Notice of Intent to Participate in the HPE Program and a Memorandum of Understanding with

EOHHS for the qualified hospital established by EOHHS. In the event a qualified hospital does not meet acceptable performance standards, participation in the HPE may be suspended or terminated at the discretion of the EOHHS.

4.9 Office of Program Integrity Agency Authority

The EOHHS may undertake an array of actions to assess whether qualified hospitals are meeting the performance standards for the program. The EOHHS Office of Program Integrity (OPI) has been assigned responsibility for performing routine audits and intensive reviews of the HPE program, as appropriate. The OPI is also responsible for overseeing the development and submission of any hospital Corrective Action Plans deemed warranted. The OPI initial audits will commence within the first six (6) months of the program's start-up date and then be performed annually thereafter or as needed.

4.10 Corrective Action

A. In the event a qualified hospital does not achieve proficiency on the performance requirements outlined in § 4.8 of this Part, the EOHHS may require the development of Corrective Action Plan (CAP) indicating interventions the hospital proposed to take to achieve compliance with these and/or other contractual standards. The OPI is responsible for reviewing and monitoring compliance with the CAP. HPE determinations may be suspended while the CAP is being prepared or implemented, as appropriate.

B. EOHHS reserves the right to request modifications to the CAP if the CAP is deemed ineffective to achieve compliance;

C. The qualified hospital must submit weekly CAP reports to EOHHS measuring the outcome of the corrective actions the hospital has instituted;

D. HPE suspensions remain in full force and effect until such time as the hospital demonstrates to EOHHS that it has instituted corrective measures to bring the hospital into full compliance with State and federal requirements.

4.11 For Further Information or to Obtain Assistance

For further information or to obtain assistance, please contact: 1-855-697-4347.

4.12 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.

Chapter 30 - Medicaid for Children, Families, and Affordable Care Act (ACA) Adults

Subchapter 00 - Affordable Coverage Groups

Medicaid MAGI Financial Eligibility Determinations and Verification" (210-RICR-30-00-5)

5.1 Scope and Legal Authority

A. The purpose of this rule is to: describe the Modified Adjust Gross Income (MAGI) standard and explain how it is applied; and establish the role and responsibilities of the State and consumers when determining MAGI-related eligibility for the Medicaid Affordable Care Coverage (MACC) groups identified in Part 1 of this Chapter.

B. This Part is promulgated pursuant to:

1. Federal authorities as follows:

a. Federal Laws -Title IVE, Title XIX, Title XXI of the U.S. Social Security Act and ACA (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15).

b. Federal Regulations - 42 C.F.R. §§ 435.603; 435.902-910; 435.916. 435.1005

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

2. State authorities - R.I. Gen. Laws Chapters 40-6, 40-8, 42-7.2.

5.2 Definitions

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

1. "Affordable Care Act" or "ACA" means the federal Patient Protection and Affordable Care Act of 2010.

2. "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.

3. "Caretaker" or "Caretaker relative" means any adult living with a Medicaid-eligible dependent child that has assumed primary responsibility for that child as defined in Part 1 of this Subchapter.

4. “Custodial parent” means a relationship that is defined by a court order or binding separation, divorce or custody agreement establishing physical custody of a minor child. If no order or agreement exists, or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

5. “Federal poverty level” or “FPL”, as used herein, means the most recently published federal poverty level by the U.S. Department of Health and Human Services.

6. “Federal data hub” or “Data hub” means the database of the United States population built by the U.S. Internal Revenue Service (IRS) and Health and Human Services (HHS) used to facilitate determinations for coverage, including Medicaid, under the ACA.

7. “HealthSource RI” means the entity that allows persons, families, and small businesses to access insurance, as well as federal subsidies to assist in the payment of that coverage.

8. “Household composition” means, for the purposes of determining MAGI eligibility, the person(s) filing taxes, whether jointly or separately, and anyone included as a tax dependent of the person(s) filing taxes. Special relationship rules for household composition may apply when the person filing taxes is not the custodial parent of the tax dependent.

9. “MAGI” means modified adjusted gross income, adjusted by any amount excluded from gross income under section 911 of the IRS Code, and any interest accrued.

10. “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.

11. “Non-MAGI coverage group” means a Medicaid coverage group that is not subject to the modified adjusted gross income standard for eligibility determination.

12. “Reasonable compatibility” means an allowable difference or discrepancy between the information provided in the application and the information reported by an electronic data source.

13. “Reconciliation” means the point in the verification process when discrepancies between an applicant’s attestation and information from data sources are resolved.

5.3 MAGI Household Construction

A. The principal factor for determining MAGI-based eligibility is - tax filing status and household composition and size, based on the rules for household construction.

1. General rules of household construction -- For the purposes of calculating MAGI, a household consists of an applicant and the people the applicant claims as a deduction for a personal exemption when filing federal income taxes. Under IRS rules, the taxpayer may claim a personal exemption deduction for him/herself, a spouse, and tax dependents. Non-family members may be included as tax dependents under certain circumstances and are treated as part of the tax household accordingly.

2. Special Medicaid rules of household construction - The following rules for constructing a household are applied when making MAGI-based Medicaid eligibility determinations:

a. “Relationship-based” rules are used when an applicant is neither filing taxes nor being claimed as a tax dependent, and under the exceptions outlined in § 5.4 of this Part.

b. Medicaid household rules are “person specific” within a family. Therefore, a Medicaid household must be constructed for each person within a family.

c. For married couples living together, each spouse must be included in the household of the other spouse, regardless of whether they expect to file a joint federal tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse.

d. If a pregnant woman is applying for coverage or is part of another applicant’s household, the household size must be adjusted to reflect the number of children that she is expecting. Specifically, the pregnant woman is counted as one plus the number of children she expects to deliver. This pregnancy-adjusted household size is used to determine the applicable FPL for the pregnant woman as well as for other members of her household.

5.4 Exceptions Requiring Application of Relationship Household Rules

A. Relationship-based household composition rules must be applied when an applicant meets the criteria for an exception from the tax-based household rules. These alternative relationship-based rules must be used to determine both household size and the income of the household members included as part of total household income.

1. Relationship-based rules --The household is determined based upon the family members who live with the applicant. The rules vary slightly for children versus adults.

a. Adults. The relationship-based rules for adults require that the household consist of the following persons:

(1) The adult applying for coverage;

(2) The applicant's spouse, if living with the applicant;

(3) The applicant's biological, adopted, and step-children under age 19 years, if living with the applicant.

b. Children under age 19. The relationship-based rules for minor children require that the household consist of the following persons:

(1) The child applying for coverage; and the child's parents (including step-parents), if living with the child;

(2) Any of the child's siblings (including step-siblings), if living with the child.

2. Triggers --The exceptions that trigger the use of relationship-based rules are as follows:

a. Applicant does not plan to file taxes and does not expect to be claimed as a tax dependent by another tax filer. Full information on who is required to file taxes under federal law is located in IRS Publication 501 (IRS Publication 501 is available at: http://www.irs.gov/publications/p501/ar02.html#en_US_2012_publink1000220851).

b. Tax dependents meet specified criteria. In situations in which an applicant will be claimed as a tax dependent on another person's federal tax form, the relationship-based rules apply if the applicant meets any of the following criteria:

(1) Applicant is claimed or expects to be claimed by a tax filer who is not the applicant's parent or step-parent.

(2) Applicant lives with both parents, but only one parent will claim the child as a tax dependent. In this case, child refers to the parent-child relationship and not the age of the applicant.

(3) Applicant is a child under 19 who lives with a custodial parent, but will be claimed as a tax dependent by a non-custodial parent.

3.

Summary of Application of Relationship-Based Rules

Applicant is not planning to file taxes and is not claimed as a tax dependent by another tax filer
Applicant is claimed as a dependent by a tax filer who is not the applicant's parent
Applicant is a child under 19 who lives with both parents, but only one parent will claim the child as a tax dependent
Applicant is a child under 19 who lives with a custodial parent, but will be claimed as a tax dependent by the non-custodial parent

5.5 Determination of Household Income

A. To be eligible for Medicaid using the MAGI standards, an applicant's current monthly household income must meet the standard applicable to the applicant's MACC group when converted to the FPL as shown below:

MACC Groups	FPL Eligibility Threshold
ACA Expansion Adults	133%
Children and Young Adults	261%
Parents and Caretakers	136%
Pregnant Women	253%

B. When calculating whether an applicant is income-eligible for Medicaid under one of these coverage groups, the following factors must be considered: the members of the applicant's household that must be included; types of countable income; current income and reasonably predicted changes; and conversion of monthly income to the FPL standards.

1. Countable household income -- The subsection below identifies all forms of countable income included when determining MAGI-based Medicaid eligibility, including those that are specific to Medicaid eligibility only.

a. Adjusted Gross Income (AGI). Adjusted gross income is gross income adjusted by "above-the-line" deductions. AGI includes wages and salaries and income from a broad array of other sources, such as unemployment benefits, alimony, taxable interest, and capital gains. "Above-the-line" deductions are the adjustments people can make to their gross income. These include alimony payments, interest on student loans, and other items that appear on page one of Form 1040. However, they do not include charitable contributions, mortgage interest and other "below-the-line" deductions.

b. Social Security benefits. All Social Security income benefits are considered countable income when using the MAGI standard to determine eligibility for affordable coverage. This includes Social Security benefits that are considered both taxable and non-taxable income for federal tax purposes.

c. Interest Income. Income received from bank accounts, money market accounts, certificates of deposit, and deposited insurance dividends are considered countable taxable income. Additionally, interest on some bonds issued by and used to finance state and local government operations is also counted for the MAGI even though treated as tax-exempt for federal tax purposes.

d. Foreign earned income. Foreign earned income is countable for the MAGI. This includes all income received from sources within a foreign country or countries earned for services when either performed by: a U.S. citizen and a bona fide resident of a foreign country for an uninterrupted period of time that includes an entire tax year; or a U.S. citizen or resident who, during any period of 12 consecutive months, is present in a foreign country for at least 330 full days during that period.

e. Medicaid specific adjustments to income. Special Medicaid adjustments are as follows:

(1) Taxable lump sum payments (such as gifts, prizes, income and property tax refunds) are counted only in the month received.

(2) Educational scholarships, awards or fellowships used for education purposes are excluded from consideration as income.

(3) Certain types of income for American Indian/Alaska Native persons are excluded.

f. Treatment of other sources of income for Medicaid eligibility are summarized in the table that follows:

MAGI-Based Medicaid Eligibility Rules	
Income Source	**Treatment of Income**
Self-employment income	Counted with deductions for most expenses, depreciation, and business losses
Salary deferrals (flexible spending, cafeteria and 401(k) plans	Not counted
Child support received	Not counted

MAGI-Based Medicaid Eligibility Rules	
Income Source	**Treatment of Income**
Alimony paid	Deducted from income
Veterans' benefits	Not counted
Workers' compensation	Not counted
Gifts and inheritances	Not counted
TANF and SSI	Not counted

2. Household members included in MAGI calculation -- An individual's household income is the sum of the MAGI-based income of every individual included in the individual's household who is expected to be required to file a tax return. These rules are based on whether or not a person is "expected" to be required to file a tax return; it does not matter whether they eventually do so or not.

3. Use of current income and accounting for reasonably predicted changes -- For new Medicaid applicants, the State must use a household's current monthly income and household size when evaluating eligibility. A prorated portion of reasonably predictable changes in income, if there is a basis for anticipating the changes, such as a signed contract for employment, a clear history of predictable fluctuations in income, or other indications of future changes in income may be considered in determining eligibility. Future changes in income and household size must be verified in accordance with the verification and reasonable compatibility requirements as delineated in this Part.

4. Comparing household income to the FPL - To determine income eligibility for Medicaid based on the MAGI calculation, the State must compare a household's current monthly income to the FPL guidelines for the appropriate household size. The State must use the most recently published FPL level in effect in the month during which an applicant applies for coverage. If an applicant's FPL level is within five (5) percentage points over the FPL for the coverage group for which they would be eligible, a disregard of five (5) percentage points of the FPL shall be added to the highest income eligibility standard listed above for that coverage group.

5.6 Verification of Income Using the MAGI Methodology

A. To achieve the ACA's goal of improving and streamlining access to all forms of affordable coverage, including Medicaid, the federal government established a data hub containing information related to various eligibility factors. The federal data hub

facilitates the electronic information exchange necessary to verify eligibility both at the time of initial application and during annual renewals thereafter. States have the flexibility to augment the electronic verification process the federal data hub uses with any additional data bases deemed appropriate. Rhode Island elected to use state level databases to verify income first as they tend to be more correct, but still uses the federal data hub, as appropriate.

B. The purpose of § 5.7 of this Part is to identify the principal facets of the verification process, including the electronic matches made through the federal data hub, and State-automated data bases and alternatives. In addition, the provisions of this rule also set forth the respective roles and responsibilities of the EOHHS, in its capacity as the Single State Medicaid Agency and applicants in assuring this process functions in the most secure, effective, and efficient manner possible.

5.7 Verification Process

A. As indicated in Part 10-00-3 of this Title, attestations are accepted without verification for residency, household composition, pregnancy and caretaker relative status. In general, this verification process proceeds as follows:

1. Data matching - The State must assure that an applicant's information is entered into the integrated eligibility system (IES) and matched electronically to the full extent feasible through the federal data hub and State data sources.

a. Federal Data Hub. The federal data hub contains electronic information from various agencies of the United States government, including the IRS, Social Security Administration (SSA), HHS (Centers for Medicare and Medicaid Services (CMS) and other agencies), Department of Homeland Security (USDHS), Department of Veterans Affairs (VA), Department of Defense (DoD), Peace Corps, and Office of Personnel Management (OPM). Various categories of data from these sources are used to match on income, employment, health, entitlements, citizenship, and criminal history. A full list of the data included in the federal hub and the rules governing its use are located in 42 C.F.R.§§ 435.948, 435.949.

b. State data sources. The State draws from databases from an array of public agencies to verify income including the RI Department of Labor and Training (DLT), Divisions of Revenue and Motor Vehicles, and EOHHS agencies including DHS. Specific databases include State Wage Information Collection Agency (SWICA) and state unemployment compensation information (UI).

2. Reasonable compatibility - The State must use a reasonable compatibility standard - or an allowable difference - to match data sources with self-reported application information. If the data sources match the applicant's attestation, or are found "reasonably compatible," the State must ensure that the IES bases the

determination on the information in the application. The State uses this standard for income verification and may apply it to other eligibility factors in the future.

3. Reasonable explanation - The State must provide the applicant with the opportunity to provide an explanation and documentation if the data sources do not match the attestation, or are not reasonably compatible. Accordingly, the IES issues a request to the applicant for this information and provides a list of reasonable explanation options.

4. Reconciliation process - The explanation provided by an applicant must be used to determine whether it is feasible to reconcile a discrepancy between an attestation and data matches to determine whether reconciliation is feasible. If the applicant provides a reasonable explanation, the final determination of eligibility will be based on the information the applicant provided. If the applicant is unable to provide a reasonable explanation, documentation will then be required to verify or correct the attestation and reconcile the discrepancy.

5. Privacy - The verification process utilizes personally identifiable information (PII) from both the federal data hub and State data sources. An account is maintained for each person who completes and submits an application through the State's IES. This account includes PII and other eligibility-related information used in the determination and annual renewal process. The State must assure the privacy of the information in these accounts in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information and R.I. Gen. Laws §§ 40-6-12 and 40-6-12.1. Also, the State must limit any use of account information to matters related to the administration of the Medicaid program including eligibility determinations, Medicaid health plan enrollment, appeals, and customer services. See also Part 10-05-1 of this Title (Confidentiality Rule).

6. Account Duration-- Once an account in the IES is established, a person seeking Medicaid has ninety (90) days to complete and submit the application for a determination. The IES eliminates the account and all eligibility information from all sources, federal and State, if an application has not been completed by the end of that period. The State must determine eligibility within thirty (30) days from the date the competed application is submitted.

7. Post-eligibility verification - See § 5.14 of this Part.

B. The following lists key eligibility factors, the types of verification required for attestations, if any, and the verification sources for MACC Group applicants/ beneficiaries:

1. Identity - An applicant must provide proof of identity when applying through the IES or filing a paper application. The requirements related to identify proofing are set forth in § 3.5 of this Subchapter. Certain applicants may not be able to obtain identity proofing through the federal hub due to data limitations. Pre-

eligibility verification is required through an alternative electronic paper documentation source in these instances to establish an account.

2. Income - Electronic verification of attested income is required by the State. Multiple electronic data sources may be used for this purpose. In general, State data sources (such as State Wage Information Collection Agency [SWICA] and State Unemployment Compensation [UI] will be used first. The reasonable compatibility standard applies when there are discrepancies between the applicant's income self-attestation and information from electronic data sources.

3. General Eligibility - Non-Financial Factors - (Social Security Numbers, Age, Citizenship, Death, Date of Birth, Residency, and Incarceration). Information on these eligibility factors is verified against various state and federal data sources. Information specific to verification requirements for MAGI populations is located in § 3.5 of this Subchapter; for Medicaid and CHIP-funded eligibility more generally, the applicable provisions are set forth in § 3.3 of this Subchapter.

5.8 Medicaid Reasonable Compatibility Standards

A. When information obtained through the federal data hub and State data sources is found reasonably compatible with the applicant's attestation, no further verification is required and the eligibility determination will proceed. The reasonable compatibility standards set forth below by the State are applicable to income verification. The term "data" refers to information obtained through electronic data matches across federal and State sources.

B. Overview of Standards

Medicaid Reasonable Compatibility Standards for Income	
Attestation and Data Scenario	**Reasonable Compatibility Standard**
Attestation and SWICA and UI data are below applicant's Medicaid eligibility levels	Reasonably Compatible: Person eligible for Medicaid
Attestation and SWICA and UI data are above applicant's Medicaid eligibility levels	Reasonably Compatible: Person ineligible for Medicaid; eligibility for a qualified health plan (QHP) is determined
The attestation is below the applicant's Medicaid eligibility level and the SWICA and UI data are above the applicant's Medicaid eligibility level, and the difference between the attestation and data is 10% or less	Reasonably Compatible: Person eligible for Medicaid

Medicaid Reasonable Compatibility Standards for Income	
Attestation and Data Scenario	**Reasonable Compatibility Standard**
The attestation is below the applicant's Medicaid eligibility level and the SWICA and UI data are above the applicant's Medicaid eligibility level, and the difference between the attestation and data is greater than 10%	Not Reasonably Compatible: pursue discrepancy reconciliation. Person may provide a reasonable explanation and/or provide the State with documentation of current income.

1. Income attestation and data are both below Medicaid eligibility levels -- Attestation and data sources are reasonably compatible if the difference or discrepancy between the two does not affect the eligibility of the applicant. In other words, even if there is a difference between what an applicant says he or she earned and what the data shows was actually earned, the attestation and data are considered reasonably compatible if both are below Medicaid eligibility levels.

2. Attestation and data are both above Medicaid eligibility levels -- Attestation and data sources are reasonably compatible if they are both above the Medicaid eligibility levels. Under such a scenario, the person would be found ineligible for Medicaid. For example, this would occur if an applicant attests to income above the eligibility ceiling for the applicable MACC group and electronic data-based verification indicates that the applicant's income is higher than that amount. The applicant is not eligible for Medicaid in either case. Eligibility for affordable care with federal advance premium tax credits and cost-sharing reductions is then reviewed.

3. Income attestation -- The difference between the income attestation and the data is less than 10% -- An income attestation and data from electronic sources are considered reasonably compatible if the difference between the applicant's attestation and the data sources is less than 10%. The applicant is eligible, provided all other eligibility criteria are met.

4. Income attestation -- The difference between the income attestation and data sources is greater than 10%. An income attestation and data on income sources are considered to be not reasonably compatible if the difference between the applicant's attestation and data sources is greater than 10%; a reasonable explanation is pursued.

5.9 Reasonable Explanations

A. When attestation and data sources are not reasonably compatible, the IES provides the applicant with prompts for resolving any identified discrepancies. The applicant is asked first to provide an explanation. Before an eligibility determination is made, the applicant

will be afforded an opportunity to explain any discrepancies between their income attestation and the income source data.

B. The following chart is a list of acceptable explanations when there is a discrepancy between an income attestation and data sources. If the applicant provides any one of these explanations, eligibility will be based on their attestation and no further verification is required. The State has only implemented reasonable explanation options for income discrepancies.

Reasonable Explanations for Discrepancy in Income	
Lost job	Fluctuating income
Decrease in hours	Work on commissions
Multiple employers	Income from capital gains
Self-employed	Income from dividends
Do not file taxes	Income from royalties
Have not filed taxes yet	Seasonal worker
Homeless	Divorce or marriage
Victim of domestic violence	Death in family
Victim of natural disaster	Victim of identity theft

5.10 Reconciliation Period

If the applicant's data verification is not reasonably compatible with the attested information and the applicant has been unable to provide a reasonable explanation for discrepancies, applicants will be given a thirty (30) day application period to submit satisfactory documentation. Medicaid eligibility is only available during the reconciliation period as specified § 5.11 of this Part below.

5.11 Satisfactory Documentation and Alternative Forms of Verification

A. During the reconciliation process, applicants will be asked to submit satisfactory documentation to verify income eligibility as indicated below:

Income Verification Sources	
Pay stubs representative of the last four (4) weeks of income	Reports from Social Security Veteran's Administration and other agencies

Income Verification Sources	
Earnings Statement Employment Letter Book Keeping Records Property Unit Proof Owner Occupied Proof Monthly Rental Income Proof Mortgage Breakdown Proof Income Tax Returns	When the applicant is unable to obtain the information requested, Departmental forms (Wage Report, AP-50; Bank Clearance, AP-91; Clearance with VA, AP-150 and AP-151) are used.

B. The State may provide an alternate verification process. This alternative process is available when one or more of the following conditions apply:

1. The IRS's only tax data for the applicant is over two years old;

2. The applicant attests that the family size or family members have changed since the tax information being used for the determination was filed;

3. The applicant attests that a change in circumstances has occurred or is reasonably expected to occur that may affect eligibility;

4. The applicant attests to a change in tax filing status that has or is reasonably expected to change the tax filer's annual income; or

5. An applicant in the tax filer's family has applied for unemployment benefits.

5.12 Post-Eligibility Verification (PEV) by the Integrated Eligibility System (IES)

A. The IES will conduct post-eligibility verification of the beneficiary's information. The IES runs post-eligibility verifications on the following beneficiary information:

1. Factors reviewed -

a. Incarceration status (Rhode Island Department of Corrections data)

b. Death data (Department of Health Vital Records data)

c. Current Income - Wages (Department of Labor and Training - SWICA)

d. Current Income - Unemployment Income (UI) (Department of Labor and Training).

2. Timelines -

a. Post-eligibility verification for incarceration, death data, and current unemployment insurance information will be checked monthly.

b. Post-eligibility verification for current income/wages runs approximately every ninety (90) days (such as February, May, August, and November).

3. PEV Results - The State may take the following action or actions based upon the PEV process:

a. All information is current and accurate and the difference between the total attested income supplied by the beneficiary and the information supplied by an external data source(s) is within the state's established reasonable compatibility standard, no action on the part of the State or the beneficiary is required. The beneficiary continues to receive benefits without interruption.

b. During the post-eligibility verification process, if the income from electronic data sources is above the applicable Medicaid eligibility threshold, and the difference between the electronic data source and the total attested income is more than ten percent (10%), the IES will check each line of income and send out a notice to the beneficiary(ies) indicating the source of income that cannot be verified and requesting that it be reviewed and verification documentation related to current income be provided.

(1) The beneficiary will have ten (10) days to respond to such a notice. The ten-day period begins on the fifth day after the notice was mailed by the State. The beneficiary may either log onto the automated account (www.healthyrhode.ri.gov) and change information, send via U.S. mail, or bring the documentation to a local DHS office. Upon receipt of the verification documentation, the State will redetermine eligibility.

(2) After the time period to provide documentation has elapsed, if the person has not provided documentation or reported a change, the State will redetermine eligibility using the data from external sources.

(3) If any member of the beneficiary's household has died or if there is a change in the household composition, the State will seek further information from the beneficiary before terminating

coverage. If terminated, the beneficiary will then have to re-apply (i.e., log onto the automated account (www.healthyrhode.ri.gov); send via U.S. mail; or bring the documentation to a local DHS office).

(4) A notice of the beneficiary's new eligibility status will be sent, along with a Medicaid termination notice with appeal rights (Part 10-05-2 of this Title, as applicable).

B. A beneficiary will not be terminated by the State based on a change in income without first considering other possible categories of eligibility based on factors including age, disability status, and level-of-care needs.

Chapter 30 - Medicaid for Children, Families, and Affordable Care Act (ACA) Adults

Subchapter 05 - Service Delivery Options

Medicaid Managed Care Delivery Options (210-RICR-30-05-2)

2.1 RIte Care Overview

A. RIte Care was initially established as a statewide managed care demonstration project in 1994 under a Medicaid Title XIX Section 1115 waiver. The project's goal was to use a managed care delivery system to increase access to primary and preventative care for certain individuals and families who otherwise might not be able to afford or obtain affordable coverage. Medicaid members participating in RIte Care are enrolled in a managed care organization (MCO). EOHHS contracts with MCOs to provide these health services to members at a capitated rate (fixed cost per enrollee per month). RIte Care managed care plans serve the following MACC coverage groups: families, children, parent caretakers, foster children (DCYF custody), and pregnant women.

B. Individuals and families who have access to employer-sponsored health insurance plans are evaluated for participation in the RIte Share Premium Assistance Program in accordance with provisions contained in "RIte Share Premium Assistance Program" (Part 3 of this Subchapter). Adults in these families are required to enroll any Medicaid-eligible family members in a RIte Share approved plan as a condition of retaining Medicaid eligibility. Medicaid is provided on a fee-for-service basis for certain beneficiaries in the populations RIte Care plans serve.

2.2 Scope and Purpose

A. The purpose of this rule is to describe the RIte Care delivery system and the respective roles and responsibilities of EOHHS and the individuals and families that are receiving affordable coverage through a RIte Care MCO.

B. This rule is consistent with the federal managed care rules (42 C.F.R. Parts 431, 433, 438, *et seq*. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule) published in March 2016 that contain, among other provisions, certain mental health parity requirements added to the Public Health Service Act (PHS Act) by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. 110-343, enacted on October 3, 2008). Such parity provisions (42 C.F.R. Parts 438, 440, 456, and 457) prohibit health plans from applying treatment limitations on mental health and substance use disorders (SUDs) that would be more restrictive than those applied to medical/surgical benefits.

2.3 Program Management

Title XIX of the U.S. Social Security Act provides the legal authority for the RI Medicaid program. The RIte Care program operates under a waiver granted by the Secretary of Health and Human Services (HHS) pursuant to Section 1115 of the Social Security Act. The RIte Care Managed Care Consumer Advisory Committee was established by Executive Order in February 1994. The Committee is available to RIte Care consumers to address suggestions, complaints, or related issues.

2.4 Definitions

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

1. “Advance practice provider” or “APP” means and includes physician assistants, certified nurse practitioners, psychiatric clinical nurse specialists, and certified nurse midwives. These individuals must maintain compliance with all applicable statutes and regulations and not exceed their scopes of practice.

2. “Appeal” means a formal request by a covered person or provider for reconsideration of a decision, such as a utilization review recommendation, a benefit payment, or administrative action.

3. “Applicant” means a person seeking Medicaid coverage under this Part, in accordance with the provisions established in Rhode Island General Laws and Public Laws.

4. “Care manager” means a nurse or social worker with specialized training in providing care management services.

5. “Complementary alternative medicine” or “CAM” means treatment from a chiropractor, acupuncturist, and/or massage therapist.

6. “Days” means calendar days.

7. “Employer sponsored insurance” or “ESI” means health insurance or a group health plan offered to employees by an employer. This includes plans purchased by small employers through HealthSourceRI.

8. “Enrollee” means a Medicaid member or “beneficiary” who is enrolled in a Medicaid managed care plan.

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

Social Security Act (42 U.S.C. § 1396a *et seq*.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

10. “Grievance” means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to:

a. quality of care or services provided;

b. aspects of interpersonal relationships such as rudeness of a provider or employee;

c. failure to respect the member’s rights regardless of whether remedial action is requested;

d. right to dispute an extension of time proposed by the MCO to make an authorization decision.

11. “In lieu of services” means cost effective alternative services/equipment, even where those services/equipment are not identified as an in-plan benefit, when the use of such alternative services/equipment are medically appropriate and cost effective, such as the purchase of an air conditioner, where clinically appropriate, which helps a beneficiary avoid hospitalization.

12. “Limited English proficiency” or “LEP” means that enrollees do not speak English as their primary language and may have a limited ability to read, write, speak, or understand English and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

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

14. “Medicaid affordable care coverage 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 as follows:

a. Families and Parents/Caretakers with income up to 141% of the Federal Poverty Level (FPL) - Includes families and parents/ caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

b. 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, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

c. Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

d. Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. 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, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

15. "Medicaid Code of Administrative Rules" or "MCAR" means the collection of administrative rules governing the Medicaid program in Rhode Island that is being revised and re-codified as the "Rhode Island Code of Regulations" or "RICR."

16. "Medically needy" means a classification of persons eligible to receive Medicaid based upon similar characteristics who are subject to the MAGI standard for determining income eligibility.

17. "Navigator" means a person working for a State-contracted organization with certified assisters who have expertise in Medicaid eligibility and enrollment.

18. "Non-MAGI coverage group" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or living with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly-funded program, including children in foster care, anyone receiving Supplemental Security Income (SSI) or eligible for or enrolled in the Medicare Premium Assistance Program.

19. "Peer navigator" means paraprofessionals with specialized training who are community resource specialists employed and supervised by peer advocacy organizations.

20. "Prospective Medicaid enrollee" means a Medicaid beneficiary or family who has not enrolled in an MCO.

21. “Prudent layperson standard” means the standard used to determine the need for an emergency room visit. An “emergency” is defined as a condition that a prudent layperson “who possesses an average knowledge of health and medicine” expects may result in:

a. placing a patient in serious jeopardy;

b. serious impairment of bodily function; or

c. serious dysfunction of any bodily organs.

22. “Rhody Health Partners” means the Medicaid managed care program that delivers affordable health coverage to eligible adults without dependent children, ages 19 to 64, under § 2.18 of this Part and adults with disabilities eligible under Part 40-10-1 of this Title.

23. “RIte Care” means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age 19, young adults older than age 19, and foster children (DCYF custody) (see § 2.1 of this Part).

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

25. "Urgent medical problem” means a medical, physical, or mental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four hours could reasonably be expected to result in:

a. Placing the patient's health in serious jeopardy;

b. Serious impairment to bodily function; or

c. Serious dysfunction of any bodily organ or part.

2.5 Coverage Groups in RIte Care

A. The RIte Care population consists of members of: certain Medicaid affordable care coverage (MACC) groups; coverage groups whose eligibility is NOT based on the MAGI standard (non-MAGI) and several non-Medicaid coverage groups.

1. Medicaid Affordable Care Coverage (MACC) Groups -- RIte Care plans provides coverage for individuals and families in the following MACC groups:

a. Families with income up to 116 % of the FPL and parents and caretaker relatives with income between 116 % and 141% of the FPL who have dependent children up to age 18 or, if attending school full-time, up to age 19.

b. Pregnant women with family income up to 253% of the FPL, including non-citizen pregnant women.

c. Children up to age 19 with family income up to 261% of the FPL, including qualified non-citizen children.

2. Non-MAGI MACC Beneficiaries - RIte Care MCOs also provide health services to:

a. Children up to age 18 or 19 if completing school who are in foster care and/or receiving adoption subsidy under the applicable provisions of Title IV-E of the federal Social Security Act (See Medicaid Code of Administrative Rules, "Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways" (§§ 00-1.7(F)(3) through (4) of this Chapter).

b. Children up to age 21 who are Medicaid eligible as result of receiving Supplementary Security Income (SSI). Individuals in the SSI eligible group under age twenty-one (21) who are enrolled in RIte Care managed care may continue enrollment in a RIte Care MCO when they turn twenty-one (21) years of age until such time as SSI eligibility is discontinued.

c. Young adults aging out of foster care between the ages of 18 and 26. Young adults who were in participating in foster care, kinship, and guardianship programs authorized by the RI Department of Children, Youth and Families (DCYF) on the date they turned 18 are eligible, without regard to income, for continued Medicaid coverage until the age of 26 under the Foster Care Independence Act of 1999, as amended by the Affordable Care Act of 2010. Members of this population are only eligible in Rhode Island if they were residing in the State at the time they aged out of DCYF foster care. EPSDT services continue only up to age 21 for members of this non-MAGI coverage group.

2.6 Excluded Medicaid Coverage Groups

A. There are MACC group beneficiaries who receive coverage on a fee-for-service basis rather than through a RIte Care plan, as follows:

1. Members of these coverage groups who are covered by employer-sponsored or other third-party health insurance, may receive Medicaid on a fee-for-service basis, rather than through enrollment in a RIte Care MCO:

a. IV-E foster children and children receiving adoption subsidy (See "Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways," § 00-1.7(F)(3) of this Chapter).

b. SSI recipients under age twenty-one (21) (Part 50-10-3 of this Title).

c. Children with disability - Katie Beckett Eligible. (Part 50-10-3 of this Title). Children under age nineteen (19) who: are living at home; require a hospital, nursing home or ICF-ID level of care; and would qualify for Medicaid if in a licensed health care institution.

d. SSI recipients over age twenty-one (21).

2. Medically needy populations. Flex-test cases are included in the RIte Care program but receive services in the fee-for-service system. With the exception of Katie Beckett children, long-term care coverage groups (Part 50-00-3 of this Title) do not receive services through a RIte Care MCO.

3. Extended family planning group. Beneficiaries eligible through this pathway in this RIte Care waiver group are entitled to a limited scope of services rather than comprehensive benefits. The group consists of women who meet the following conditions: income must be above the Medically Needy income limit; if pregnant, income must not exceed 253% of FPL; the women must be sixty (60) days postpartum or sixty (60) days post-loss of pregnancy and, as a result, subject to discontinuation of Medicaid eligibility. Coverage is available for up to twenty-four (24) months.

2.7 Retroactive Coverage

Requests for retroactive eligibility are evaluated at the time of application, but must not delay a decision on prospective eligibility. Retroactive eligibility is not available to MACC groups enrolled in RIte Care. Foster and adoption subsidy children in Non-MAGI coverage groups are eligible for retroactive coverage if eligible for SSI. Retroactive coverage is also available to SSI-related eligible individuals and SSI-related medically needy flex-test cases. If eligibility exists, retroactive payment for services is on a fee-for-service basis and does not exceed a three-month time period.

2.8 Overview of RIte Care Services

A. Individual and families enrolled in RIte Care receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver, unless otherwise indicated. Covered services may be provided through the MCO or through the fee-for-service delivery system if the service is "out-of-plan" - that is, not included in the MCO but covered under Medicaid. Fee-for-service benefits may be furnished by any participating provider. Rules of prior authorization apply to any service required by EOHHS. Each RIte Care member selects a primary care provider (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care provider orders treatment determined to be medically necessary in accordance with MCO policies. Beneficiaries in the Extended Family Planning (EFP) coverage group do not require a PCP. The extended family planning group is entitled only to family planning services.

1. Access to Benefits - Unless otherwise specified, members of all RIte Care coverage groups (MACC, Non-MAGI) are entitled to a comprehensive benefit package that includes both in-plan and specific out-of-plan services. Categories of eligibility for the extended family planning benefit package are as follows:

a. Women otherwise Medicaid ineligible. The package of services is available without the comprehensive benefit package. Women who have given birth and are not eligible for Medicaid under another coverage group lose the full scope of covered services sixty (60) days postpartum or post-loss of pregnancy. Women in this category are eligible for RIte Care for a period of up to twenty-four (24) months for the full family planning benefit package. The benefit package includes interpreter services but does not include transportation benefits. Renewal is required at twelve (12) months.

b. Women who are otherwise eligible for Medicaid. Women enrolled in RIte Care are eligible for family planning services. Participation is voluntary. Members continue to be enrolled with the same MCO they selected or were assigned to for comprehensive health service delivery but for family planning services only for a twelve (12) month period. Upon renewal at twelve (12) months, a participant may qualify for up to an additional twelve (12) months. Services are covered on an outpatient basis only. Non-prescription contraceptives are covered for members in this category with a provider's order (i.e., prescription).

2. Delivery of Benefits - The coverage provided through RIte Care is categorized as follows:

a. In-Plan Benefits

b. Out-of-Plan Benefits.

3. Medical necessity - The standard of "medical necessity" is used as the basis for determining whether access to Medicaid-covered services is required and appropriate. A "medically necessary service" means medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health-related condition including any such services that are necessary to prevent a detrimental change in either medical or mental health status or substance use disorder or services needed to achieve age-appropriate growth and development or to attain, maintain, or regain functional capacity. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

4. Early Periodic Screening, Diagnosis and Treatment (EPSDT) -- The EPSDT provision in Title XIX mandates that state Medicaid programs must provide coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct defects and physical and mental illnesses and

conditions discovered through screening or at any other occasion, whether or not those services are covered by the State Medicaid Plan or the State's Medicaid Section 1115 waiver. This applies to members of the MACC group up to age nineteen (19), SSI-eligible children and young adults up to age twenty-one (21), including adults aging out of foster care up to age twenty-one (21). A young adult over age nineteen (19) who transitions from the MACC group for children and young adults to the MACC group for adults from age 19 to 64 also receives EPSDT services until age 21.

2.9 RIte Care In-Plan Capitated Benefits

A. The benefits which the MCO provides or arranges within the capitated (fixed cost per enrollee per month) benefit are set forth below.

B. In-Plan benefits subject to the capitated rate are organized as follows: the RIte Care comprehensive benefit package and the extended family planning benefit package. Adults who are found to be severely and persistently mentally ill have access to a comprehensive benefit package. All elements of the comprehensive benefit package are the responsibility of the MCO when beneficiaries in this group receive coverage through the RIte Care managed care delivery system.

C. RIte Care comprehensive benefit package --The following benefits are included in the capitated rate on an annual basis, based on medical necessity:

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Inpatient Hospital Care	As medically necessary. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in an MCO. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's MCO and enrolled in another MCO or re-enrolled into Medicaid fee-for-service, until the management of the Member's care is formally transferred to the care of another MCO, another program option, or fee-for-service Medicaid.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting.
Therapies	Covered as medically necessary, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Physician/Provider Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care.
Family Planning Services	Enrolled female members have freedom of choice of providers for family planning services.
Prescription Drugs	Covered when prescribed by an MCO physician/ provider. Generic substitution only unless provided for otherwise as described in the Managed Care Pharmacy Benefit Plan Protocols.
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the Medicaid Managed Care Pharmacy Benefit Plan Protocols. Includes nicotine cessation supplies ordered by an MCO physician. Includes medically necessary nutritional supplements ordered by an MCO physician.
Laboratory Services	Covered when ordered by an MCO physician/provider including urine drug screens.
Radiology Services	Covered when ordered by an MCO physician/provider.
Diagnostic Services	Covered when ordered by an MCO physician/provider.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Mental Health and Substance Use - Outpatient& Inpatient	Covered as needed for all members, including residential substance use treatment for youth. Covered services include a full continuum of mental health and substance use disorder treatment, including but not limited to, community-based narcotic treatment, methadone, and community detox. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days, or hospital-based detox, MH/SUD residential treatment (including minimum 6 month SSTAR birth residential services), Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST),Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs.
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician/provider/APP including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home health services do not include respite care, relief care or day care.
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician/provider including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
	client's laundry and shopping. Home care services do not include respite care, relief care or day care.
Preventive Services	Covered when ordered by a health plan physician/provider. Services include homemaker services, minor environmental modifications, physical therapy evaluation and services, and personal care services.
EPSDT Services	Provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as medically indicated. Includes multi-disciplinary evaluations and treatment, including, PT/OT/ST, for children with significant disabilities or developmental delays.
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services or when authorized by an MCO Provider, or in order to assess whether a condition warrants treatment as an emergency service.
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by an MCO physician/provider. For Rhody Health Partners/ Expansion members, the Contractor payments are limited to thirty (30) consecutive days. All skilled and custodial care covered. Contractor is responsible for notifying the State to begin disenrollment process. For RIte Care members, please refer to stop-loss provisions.
School-Based Clinic Services	Covered for RIte Care members as Medically Necessary at all designate sites.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Services of Other Practitioners	Covered if referred by an MCO physician or APP. Practitioners certified and licensed by the State of Rhode Island including social workers, licensed dietitians, psychologists and licensed nurse midwives.
Court-ordered mental health and substance use services - criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body, such as a Probation Officer, the Rhode Island State Parole Board. If the length of stay is not prescribed on the court order, the MCOs may conduct Utilization Review on the length of stay. The MCOs must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. Condition of Probation: Treatment is prescribed as a condition of probation Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Court-ordered mental health and substance use treatment - civil court	All Civil Mental Health Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the R.I. Gen. Laws § 40.1-5-5 must be followed. If the length of stay is not prescribed on the court order, the MCOs may conduct Utilization Review on the length of stay. The MCOs must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Note the following are facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be disenrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. Civil Court Ordered Treatment can be from the result of: Voluntary Admission Emergency Certification Civil Court Certification Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. Court ordered treatment is exempt from the 14-day prior authorization requirement for residential treatment.
Podiatry Services	Covered as ordered by an MCO physician/ provider.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Optometry Services	For children under 21: Covered as medically necessary with no other limits. For adults 21 and older: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.
Oral Health	Inpatient: Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. Outpatient: Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. Oral Surgery: Treatment covered as medically necessary. As detailed in the Schedule of In-Plan Oral Health Benefits updated January 2017.
Hospice Services	Covered as ordered by an MCO physician/provider. Services limited to those covered by Medicare.
Durable Medical Equipment	Covered as ordered by an MCO physician/provider as medically necessary.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.
Children's Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.
Nutrition Services	Covered as delivered by a registered or licensed dietitian for certain medical conditions and as referred by an MCO physician or APP.
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.
Interpreter Services	Covered as needed.
Transplant Services	Covered when ordered by an MCO physician.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
HIV/AIDS **Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring Risk for Acquiring HIV**	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV (see provider manual for distinct eligibility criteria for beneficiaries to qualify for this service). These services provide a series of consistent and required "steps" such that all clients are provided with and Intake, Assessment, Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible All types of case management encounters and communications (face-to-face, telephone contact, other) Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. A series of metrics and quality performance measures for both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Does not involve coordination and follow up of medical treatments.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
AIDS Medical Case Management	Medical Case Management services (including treatment adherence) are a range of client - centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the beneficiary's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIVIAIDS treatments. Key activities include 1) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time beneficiary is enrolled in services. It includes beneficiary-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other form of communication.
Treatment for Gender Dysphoria	**Comprehensive benefit package.**
Early Intervention	Covered for RIte Care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island Subject to stop loss greater than $5,000.
Rehabilitation Services	Physical, occupational and speech therapy services may be provided with physician orders by RI Department of Health-licensed outpatient rehabilitation centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider. See also EPSDT.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
In Lieu of Service	All services as provided in § 2.9(C) of this Part can be utilized as an in Lieu of Service if alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting.
Value Add Services	Services/equipment which are not in the State Plan but are cost effective, improve health and clinically appropriate.
Neonatal Intensive Care Unit (NICU)	Covered under the following circumstances: Admitted to Women and Infants (W&I) from home after discharge, admitted to W&I NICU from home after discharge from W&I Normal Newborn Nursery, Admission to non-W&I level 2 Nursery, Admission to W&I NICU from home following delivery at and discharge from non-W&I facility or discharge from non-W&I NICU with admission to W&I for continued care.

D. Extended family planning services -- The extended family planning group benefit package includes:

1. Gynecological Services. Limited to no more than four (4) office visits annually -- One (1) comprehensive gynecological annual exam and up to three (3) additional family planning method related office visits if indicated.

2. Laboratory. Includes annual Pap smear; STD screening if indicated; anemia testing; dipstick urinalysis and urine culture if indicated; pregnancy testing.

3. Procedures. Limited to the following office/clinic/outpatient procedures if indicated tubal ligation; treatment for genital warts; Norplant insertion and removal; IUD insertion and removal; incision and drainage of a Bartholin's gland cyst or abscess.

4. Includes generic-first prescriptions and non-prescription family planning methods (Limited to twelve (12) 30-day supplies per year) when prescribed by a health plan physician or APP.

5. Contraceptives. Includes oral contraceptives, contraceptive patch, contraceptive vaginal, contraceptive implant, contraceptive IUD, contraceptive injection, cervical cap, diaphragm, and emergency contraceptive pills, when prescribed by a

health care physician. Covered non-prescription methods include foam, condoms, spermicidal cream/jelly, and sponges.

6. Referrals for other medically necessary services as appropriate/indicated, including: referral to State STD clinic for treatment if indicated.

7. Referral to State confidential HIV testing and counseling sites, if indicated.

8. Inpatient services are not a covered benefit, except as medically necessary follow-up treatment of a complication from provision of a covered procedure or service.

9. Categories of eligibility for this extended family planning benefit package are as follows:

a. Women otherwise Medicaid ineligible. The package of services is available without the comprehensive benefit package. Women who have given birth and are not eligible for Medicaid under another coverage group, lose the full scope of covered services sixty (60) days postpartum or post-loss of pregnancy. Women in this category are eligible for RIte Care for a period of up to twenty-four (24) months for the full family planning benefit package. The benefit package includes interpreter services but does not include transportation benefits. Re-certification is required at twelve (12) months.

b. Women who are otherwise eligible for Medicaid. Women enrolled in RIte Care are eligible for family planning services. Participation is voluntary. Members continue to be enrolled with the same health plan they selected or were assigned to for comprehensive health service delivery but for family planning services only for a twelve (12) month period. Upon re-certification at twelve (12) months, a participant may qualify for up to an additional twelve (12) months. Services are covered on an outpatient basis only. Non-prescription contraceptives are not covered for members in this category.

E. EOHHS policy affects the access to and/or the scope and amount of several benefits as follows:

1. Prescriptions: Generic Policy. For RIte Care enrolled members, prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by EOHHS, or the MCO acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below:

a. Availability of suitable within-class generic substitutes or out-of-class alternatives.

b. Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.

c. Relative disruptions in care that may be brought on by changing treatment from one drug to another.

d. Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.

e. Relative clinical advantages and disadvantages of drugs within a therapeutic class.

f. Cost differentials between brand and generic alternatives.

g. Drugs that are required under federal and State regulations.

h. Demonstrated medical necessity and lack of efficacy on a case by case basis.

2. Non-emergency transportation (NEMT) policy. Responsibility for transportation services rests first with the member. If the member's condition, place of residence, or the location of medical provider does not permit the use of bus transportation, NEMT for the Medicaid enrollee may be arranged for by EOHHS or its agent for transportation to a Medicaid-covered service from a Medicaid-participating provider. NEMT service includes bus passes, and other RIPTA fare products, if authorized by EOHHS or its agent.

3. Interpretation services policy. EOHHS will notify the health plan when it knows of members who do not speak English as a first language who have either selected or been assigned to the plan. If the health plan has more than fifty (50) members who speak a single language, it must make available general written materials, such as its member handbook, in that language.

a. Written material must be available in alternative formats, such as audio and large print, and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services. All enrollees must be informed that information is available in alternative formats and how to access those formats.

4. Tracking, Follow-up, Outreach. These services are provided by the MCO in association with an initial visit with member's PCP; for preventive visits and prenatal visits; referrals that result from preventive visits; and for preventive dental visits. Outreach includes mail, phone, and home outreach, if necessary, for

members who miss preventive and follow-up visits, and to resolve barriers to care such as language and transportation barriers.

2.10 Out-of-Plan Benefits

A. Out-of-plan benefits are not included in the capitated rate paid to the MCOs and are not the responsibility of the MCO to provide. These services are provided by existing Medicaid-approved providers who are reimbursed directly by EOHHS on a fee-for-service basis. Out-of-plan benefits are provided to all RIte Care enrollees with the following exceptions: Individuals eligible for Extended Family Planning only; Pregnant women who are otherwise ineligible for Medicaid and post-partum women with income above 253% of FPL; and anyone enrolled in the guaranteed enrollment period but otherwise ineligible for Medicaid. The covered benefits are as follows:

ELIGIBLE GROUP	BENEFIT(S) PROVIDED OUT-OF-PLAN
All Rhody Health Partners, RIte Care and Expansion members	Dental services Court-ordered mental health and substance use services ordered to a non- network facility or provider Non-Emergency Transportation Services (Non-Emergency transportation is coordinated by the contracted Health Plans). Nursing home services in excess of 30 consecutive days (RHP members only) Residential services for MR/DD clients that are paid by the State's BHDDH Respite (Adult) Neonatal intensive care Unit (NICU) Services at Women's and Infants Hospital. Except as specified in § 2.9(C) of this Part Special Education services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays Lead Program home assessment and non- medical case management provided by Department of Health or Lead Centers for lead poisoned children Cedar Family Center Services

ELIGIBLE GROUP	BENEFIT(S) PROVIDED OUT-OF-PLAN
	Centers of Excellence Programs

2.11 Limits on Services

A. The following services are not covered under the RIte Care program:

1. Experimental procedures, except as required by RI state law;

2. Abortion services, except to preserve the life of the woman, or in cases of rape or incest;

3. Private rooms in hospitals (unless medically necessary);

4. Cosmetic surgery;

5. Medications that treat erectile dysfunction or other sexual disorders;

6. Infertility treatment services; and

7. Any portion of services that exceeds fifteen (15) days provided in an Institution for Mental Diseases (IMD) for individuals between the ages of twenty-one (21) to sixty-four (64).

B. Out-of-State Coverage

1. Out-of-State Benefits — EOHHS does not routinely provide coverage for out-of-state services with certain exceptions: Medicaid services provided in border communities are covered and emergency services are covered, within limits, at the discretion of EOHHS or the MCO.

2.12 Scope of Provider Networks

The MCO must maintain provider networks in locations that are geographically accessible to the populations to be served, comprised of hospitals, physicians, advanced practice practitioners, mental health providers, substance use disorder providers, pharmacies, transportation services, dentists, school based health centers, etc. in sufficient numbers to make available all services in a timely manner.

2.13 Mainstreaming / Selective Contracting

A. The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of the Medicaid program. The MCO must ensure that all of its network providers accept RIte Care members for treatment. The MCO also must accept responsibility for ensuring that network providers do not intentionally segregate RIte Care members in any way from other persons receiving services.

B. Health plans may develop selective contracting arrangements with certain providers for the purpose of cost containment, but must still adhere to the access standards as defined in the health plan contracts.

2.14 Primary Care Providers (PCPs)

A. The MCO has written policies and procedures allowing every member to select a primary care provider (PCP). If a member does not select a PCP during enrollment, the MCO shall make an automatic assignment, taking into consideration such factors as current provider relationships, language needs, and the relative proximity of the PCP to the member’s area of residence. The health plan must notify the member in a timely manner of his/her PCP’s name, location, and office telephone number, and how to change PCPs, if desired. The PCP serves as the member's initial and most important point of interaction with the MCO network. In addition to performing primary care services, the PCP coordinates referrals and specialty care. As such, PCP responsibilities include at a minimum:

1. Serving as the member's primary care provider;

2. Ensuring that members receive all recommended preventive and screening care appropriate for their age group and risk factors;

3. Referring for specialty care and other medically necessary services both in- and out-of-plan;

4. Maintaining a current medical record for the member; and

5. Adhering to the EPSDT periodicity schedule for members under age twenty-one (21).

B. In addition, the MCO retains responsibility for monitoring PCP actions to ensure they comply with health plan and Medicaid program policies.

2.15 Service Accessibility Standards

A. The service accessibility standards which the health plan must meet are:

1. Twenty-four-hour coverage;

2. Travel time or distance;

3. Days to appointment for non-emergency services.

B. In addition, MCOs must staff both a member services and a provider services function.

1. Twenty-Four Hour Coverage --The MCO must provide coverage, either directly or through its PCPs, to members on a twenty-four (24) hours per day, seven (7) days a week basis. The MCO must also have available written policy and procedures describing how members and providers can contact it to receive instruction or prior authorization for treatment of an emergent or urgent medical problem.

2. Travel Time --The MCO must make available to every member a PCP whose office is located within twenty (20) minutes or twenty (20) miles driving time from the member's place of residence. Members may, at their discretion, select PCPs located farther from their homes.

3. Appointment for Non-Emergency Services --The MCO must make services available within twenty-four (24) hours and seven (7) days per week, including services for mental health and substance use disorders for treatment of an urgent medical problem. The MCO must make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days. Non-emergent, non-urgent mental health or substance use appointments for diagnosis and treatment must be made available within ten (10) days.

4. Member Services -- The MCO must staff a member services function operated at least during regular business hours and responsible for the following:

a. Orienting the member to the health plan and assisting members in the selection of a PCP;

b. Assisting members to make appointments and obtain services;

c. Assisting in arranging medically necessary transportation for members;

d. Arranging interpreter services;

e. Assisting in reporting fraud, waste, and abuse;

f. Assisting members with coordination of out-of-plan services;

g. Ordering member materials, such as handbooks and provider directories;

h. Explaining to members what to do in an emergency or urgent medical situation;

i. Assisting members with questions regarding benefits and how to access services;

j. Handling members' complaints, grievances, and appeals; and

k. Providing a toll-free telephone number.

C. The MCO must maintain a toll-free Member Services telephone number. Although the full Member Services function is not required to operate after regular business hours, this or another toll-free telephone number must be staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and weekends, including pharmacy services.

D. Provider Services - The MCO must staff a provider Services function operated at least during regular business hours and responsible for the following:

1. Assisting providers with questions concerning member eligibility status and benefits;

2. Assisting providers with plan prior authorization, care coordination, network questions, and referral procedures;

3. Assisting providers with claims payment procedures;

4. Handling provider complaints.

2.16 Mandatory Participation in Managed Care

Participation in managed care is mandatory for the members of the MACC, non-MAGI and non-Medicaid funded coverage groups identified in § 2.1 of this Part except as specified in § 2.34 of this Part. Medicaid members in these coverage groups with third-party medical coverage or insurance may be exempt from this mandate only as indicated in § 2.38 of this Part at the discretion of the EOHHS.

2.17 Enrollment Procedures, Rights and Responsibilities

The enrollment process for MACC groups is set forth in § 2.34 of this Part.

2.18 Rhody Health Partners - Program Overview

A. Rhody Health Partners (RHP) is a managed care delivery system for adult Medicaid beneficiaries ages 19 to 64 eligible under the ACA expansion as well as adults with disabilities eligible under Part 40-00-1 of this Title.

B. As with RIte Care, beneficiaries under this rule who have access to a Medicaid approved employer-sponsored health insurance plans are evaluated for participation in the RIte Share Premium Assistance Program and are required to enroll in an employer plan approved by EOHHS as a condition of retaining Medicaid eligibility.

2.19 Scope and Purpose

Eligible members of the MACC group for adults ages 19 to 64 and must not be eligible for or enrolled in Medicare will be enrolled in a RHP health plan or, as applicable, RIte Share. The purpose of this section is to describe the RHP delivery system for members of this MACC coverage group and the respective roles and responsibilities of EOHHS and the individuals receiving affordable coverage through RHP.

2.20 Applicability

The provisions governing RHP for persons who are eligible for Medicaid on the basis of being aged, blind, or with a disability are located in Part 40-10-1 of this Title.

2.21 MACC Group in Rhody Health Partners

The MACC group participating in RHP is adults, ages 19 to 64, who are not: pregnant, entitled to received Medicare Part A or B, or otherwise eligible for or enrolled in a Medicaid State Plan mandatory coverage group. See: “Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways” (Subchapter 00 Part 1 of this Chapter).

2.22 Overview of RHP

Individuals enrolled in RHP receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver, unless otherwise indicated. Covered services may be provided through the MCO or through the fee-for-service delivery system if the service is "out-of-plan" - that is, not included in the MCO but covered under Medicaid. Fee-for-service benefits may be furnished either by the managed care provider or by any participating provider. Rules of prior authorization apply to any service required by EOHHS. Each RHP member selects a primary care provider (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care provider orders treatment determined to be medically necessary in accordance with MCO policies.

2.23 Access to Benefits

A. Unless otherwise specified, MACC group adults coverage groups entitled to a comprehensive benefit package that includes both in-plan and out-of-plan services. In-plan services are paid for on a capitated basis. The State may, at its discretion, identify other services paid for on a fee-for-service basis rather than at a capitated rate.

B. Delivery of Benefits - The coverage provided through the RHP is categorized as follows:

1. In-Plan Benefits

2. Out-of-Plan Benefits.

C. Medical necessity - The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered services is required and appropriate. A "medically necessary service" means medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health- related condition including any such services are necessary to prevent a decremental change in either medical or mental health status or substance use disorder or services needed to achieve age-appropriate growth and development or to attain, maintain, or regain functional capacity.

D. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

2.24 RHP In-Plan Capitated Benefits

A. The benefits which the MCO provides within the capitated (fixed cost per enrollee per month) benefit.

B. RHP comprehensive benefit package --The following benefits are included in the capitated rate on an annual basis, based on medical necessity:

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Inpatient Hospital Care	As medically necessary. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's Health Plan and enrolled in another MCO or re-enrolled into Medicaid fee-for-service, until the management of the Member's care is formally transferred to the care of another MCO, another program option, or fee-for-service Medicaid.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting.
Therapies	Covered as medically necessary, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.
Physician/Provider Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care.
Family Planning Services	Enrolled female members have freedom of choice of providers for family planning services.
Prescription Drugs	Covered when prescribed by an MCO physician/provider. Generic substitution only unless provided for otherwise as described in the Managed Care Pharmacy Benefit Plan Protocols.
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider/APP. Limited to non-prescription drugs, as described in the Medicaid Managed Care Pharmacy Benefit Plan Protocols. Includes nicotine cessation supplies ordered by an MCO physician or APP. Includes medically necessary nutritional supplements ordered by an MCO physician or APP.
Laboratory Services	Covered when ordered by a Health Plan physician/provider including urine drug screens.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Radiology Services	Covered when ordered by a Health Plan physician/provider.
Diagnostic Services	Covered when ordered by a Health Plan physician/provider.
Mental Health and Substance Use - Outpatient & Inpatient	Covered as needed for all members, including residential substance use treatment for youth. Covered services include a full continuum of mental health and substance use disorder treatment, including but not limited to, community-based narcotic treatment, methadone, and community detox. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days, or hospital-based detox, MH/SUD residential treatment (including minimum 6 month SSTAR birth residential services), Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST),Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs.
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician/provider including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by an MCO physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home health services do not include respite care, relief care or day care.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician/provider including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.
Preventive Services	Covered when ordered by a health plan physician/provider. Services include homemaker services, minor environmental modifications, physical therapy evaluation and services, and personal care services.
EPSDT Services	Provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as medically indicated. Includes multi-disciplinary evaluations and treatment, including, PT/OT/ST, for children with significant disabilities or developmental delays.
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services or when authorized by an MCO Provider, or in order to assess whether a condition warrants treatment as an emergency service.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician/provider. For Rhody Health Partners/ Expansion members, the Contractor payments are limited to thirty (30) consecutive days. Please refer to the Nursing Home Status Form Policy. All skilled and custodial care covered. Contractor is responsible for notifying the State to begin dis-enrollment process. For RIte Care members, please refer to stop-loss provisions.
School-Based Clinic Services	Covered for RIte Care members as Medically Necessary at all designate sites.
Services of Other Practitioners	Covered if referred by an MCO physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.
Court-ordered mental health and substance use services - criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body, such as a Probation Officer, the Rhode Island State Parole Board. If the length of stay is not prescribed on the court order, the MCOs may conduct Utilization Review on the length of stay. The MCOs must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. Condition of Probation: Treatment is prescribed as a condition of probation. Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
Court-ordered mental health and substance use treatment - civil court	All Civil Mental Health Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the R.I. Gen. Laws § 40.1-5-5 must be followed. If the length of stay is not prescribed on the court order, the MCOs may conduct Utilization Review on the length of stay. The MCOs must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Note the following are facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the MCO at the end of the month, and be re-assigned into Medicaid FFS. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. Court ordered treatment is exempt from the 14-day prior authorization requirement for residential treatment.
Podiatry Services	Covered as ordered by Health Plan physician/ provider.
Optometry Services	For children under 21: Covered as medically necessary with no other limits. For adults 21 and older: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
	eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.
Oral Health	Inpatient: Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. Outpatient: Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. Oral Surgery: Treatment covered as medically necessary. As detailed in the Schedule of In-Plan Oral Health Benefits updated January 2017.
Hospice Services	Covered as ordered by an MCO physician/provider. Services limited to those covered by Medicare.
Durable Medical Equipment	Covered as ordered by an MCO physician/provider as medically necessary.
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
	are for adults who return to their homes and caregivers at the end of the day.
Children's Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.
Nutrition Services	Covered as delivered by a registered or licensed dietitian for certain medical conditions and as referred by an MCO physician.
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.
Interpreter Services	Covered as needed.
Transplant Services	Covered when ordered by an MCO physician.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
HIV/AIDS **Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV**	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV (see provider manual for distinct eligibility criteria for beneficiaries to qualify for this service). These services provide a series of consistent and required "steps" such that all clients are provided with and Intake, Assessment, Care Plan. All providers must utilize an acuity index to monitor beneficiary severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals, such as HIV/AIDS, by age or health/mental health condition, or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: Benefits/entitlement counseling and referral activities to assist eligible beneficiaries to obtain access to public and private programs for which they may be eligible All types of case management encounters and communications (face-to-face, telephone contact, other) Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. A series of metrics and quality performance measures for both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Does not involve coordination and follow up of medical treatments.

SERVICE	SCOPE OF BENEFIT **(ANNUAL)** **Including but not limited to:**
AIDS Medical Case Management	Medical Case Management services (including treatment adherence) are a range of beneficiary-centered services that link beneficiaries with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIVIAIDS treatments. Key activities include 1) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time beneficiary is enrolled in services. It includes beneficiary-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other form of communication.
Treatment for Gender Dysphoria	Comprehensive benefit package.
Rehabilitation Services	Physical, Occupational and Speech therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider. See also EPSDT.
In Lieu of Service	All services as provided in § 2.9(C) of this Part can be utilized as an in Lieu of Service if alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting.
Value Add Services	Services/equipment which are not in the State Plan but are cost effective, improve health and clinically appropriate.

C. EOHHS policy affects the access to and/or the scope and amount of several benefits as follows:

1. Prescriptions: Generic Policy. For RHP enrolled members, prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by EOHHS, or the MCO acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below:

a. Availability of suitable within-class generic substitutes or out-of-class alternatives.

b. Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.

c. Relative disruptions in care that may be brought on by changing treatment from one drug to another.

d. Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.

e. Relative clinical advantages and disadvantages of drugs within a therapeutic class.

f. Cost differentials between brand and generic alternatives.

g. Drugs that are required under federal and State regulations.

h. Demonstrated medical necessity and lack of efficacy on a case by case basis.

2. Non-emergency medical transportation (NEMT) policy. Responsibility for transportation services rests first with the member. If the member's condition, place of residence, or the location of medical provider does not permit the use of bus transportation, NEMT for the Medicaid enrollee may be arranged for by EOHHS or its agent for transportation to a Medicaid covered service from a Medicaid participating provider, including medical, dental, and behavioral health care services. NEMT services include bus passes, other RIPTA fare products, if authorized by EOHHS or its agent.

3. Interpretation services policy. EOHHS will notify the MCO when it knows of members who do not speak English as a first language who have either selected or been assigned to the MCO. If the MCO has more than fifty members who speak a single language, it must make available general written materials, such as its member handbook, in that language.

a. Written material must be available in alternative formats, such as audio and large print, and in an appropriate manner that takes into consideration

the special needs of those who are visually limited or have limited reading proficiency. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services. All enrollees must be informed that information is available in alternative formats and how to access those formats.

4. Tracking, Follow-up, Outreach. These services are provided by the MCO in association with an initial visit with member's PCP; for preventive visits and prenatal visits; referrals that result from preventive visits; and for preventive dental visits. Outreach includes mail, phone, and home outreach, if necessary, for members who miss preventive and follow-up visits, and to resolve barriers to care such as language and transportation barriers.

2.25 SPMI Modifications

SPMI adults have access to a comprehensive benefit package. All elements of the comprehensive benefit package are the responsibility of the MCO when a beneficiary is enrolled in the Rhody Health Partners delivery system.

2.26 Out-of-Plan Benefits

A. Out-of-plan benefits are not included in the managed care contracts and are not the responsibility of the MCO to provide. These services are provided by existing Medicaid-approved providers who are reimbursed directly by EOHHS on a fee-for-service basis. Out-of-plan benefits are provided to all RHP enrollees with the following exceptions: anyone enrolled in the guaranteed enrollment period but otherwise ineligible for Medicaid. The covered benefits are as follows:

ELIGIBLE GROUP	BENEFIT(S) PROVIDED OUT-OF-PLAN
All Rhody Health Partners and Expansion members	Dental services Court-ordered mental health and substance use services ordered to a non- network facility or provider Non-Emergency Transportation Services (Non-Emergency transportation is coordinated by the contracted Health Plans) Nursing home services in excess of 30 consecutive days Residential services for MR/DD clients that are paid by the State's BHDDH Respite (Adult) Neonatal intensive care Unit (NICU) Services at Women's and Infants Hospital. Except as specified in § 2.9(C) of this Part Special Education services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays Lead Program home assessment and non- medical case management provided by Department of Health or Lead Centers for lead poisoned children Cedar Family Center Services (RIte Care) Centers of Excellence Programs

2.27 Services that are Not Covered by Medicaid

A. Non-covered services --The following services are not covered under the Medicaid program:

1. Experimental procedures, except as required by RI state law;

2. Abortion services, except to preserve the life of the woman, or in cases of rape or incest;

3. Private rooms in hospitals (unless medically necessary);

4. Cosmetic surgery;

5. Medications that treat erectile dysfunction or other sexual disorders;

6. Infertility treatment services; and

7. Any portion of services that exceeds fifteen (15) days provided in an Institution for Mental Diseases (IMD) for individuals between the ages of twenty-one (21) to sixty-four (64). RHP managed care enrollees may access IMDs.

B. Out-of-State Coverage -- EOHHS does not routinely provide coverage for out-of-state services with certain exceptions: Medicaid services provided in border communities are covered and emergency services are covered, within limits, at the discretion of EOHHS or the managed care organization.

2.28 Scope of Provider Networks

The MCO must maintain provider networks in locations that are geographically accessible to the populations to be served, comprised of hospitals, physicians, advanced practice practitioners, mental health providers, substance use disorder providers, pharmacies, transportation services, dentists, school based health centers, etc. in sufficient numbers to make available all services in a timely manner.

2.29 Mainstreaming / Selective Contracting

A. The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of EOHHS. The MCO must ensure that all of its network providers accept RHP members for treatment. The MCO also must accept responsibility for ensuring that network providers do not intentionally segregate RHP members in any way from other persons receiving services.

B. Health plans may develop selective contracting arrangements with certain providers for the purpose of cost containment, but must still adhere to the access standards as defined in the health plan contracts.

2.30 Primary Care Providers (PCPs)

A. The MCO has written policies and procedures allowing every member to select a primary care provider (PCP). If a member does not select a PCP during enrollment, the MCO shall make an automatic assignment, taking into consideration such factors as current provider relationships, language needs, and the relative proximity of the PCP to the member’s area of residence. The MCO must notify the member in a timely manner of his/her PCP’s name, location, and office telephone number, and how to change PCPs, if desired. The PCP serves as the member's initial and most important point of interaction with the health plan network. In addition to performing primary care services, the PCP coordinates referrals and specialty care. As such, PCP responsibilities include at a minimum:

1. Serving as the member's primary care provider;

2. Ensuring that members receive all recommended preventive and screening care appropriate for their age group and risk factors;

3. Referring for specialty care and other medically necessary services both in- and out-of-plan;

4. Maintaining a current medical record for the member; and

B. In addition, the MCO retains responsibility for monitoring PCP actions to ensure they comply with health plan and Medicaid program policies.

2.31 Service Accessibility Standards

A. The service accessibility standards which the MCO must meet are:

1. Twenty-four-hour coverage;

2. Travel time or distance;

3. Days to appointment for non-emergency services.

B. In addition, MCOs must staff both a member services and provider services function.

1. Twenty-Four Hour Coverage --The MCO must provide coverage, either directly or through its PCPs, to members on a twenty-four hour per day, seven days a week basis. The MCO must also have available written policy and procedures describing how members and providers can contact it to receive instruction or prior authorization for treatment of an emergent or urgent medical problem.

2. Travel Time --The MCO must make available to every member a PCP whose office is located within twenty minutes or twenty (20) miles driving time from the member's place of residence. Members may, at their discretion, select PCPs located farther from their homes.

3. Appointment for Non-Emergency Services --The MCO must make services available within twenty-four hours and seven (7) days per week, including services for mental health and substance use disorders for treatment of an urgent medical problem. The MCO must make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days. Non-emergent, non-urgent mental health or substance use disorder appointments for diagnosis and treatment must be made available within ten (10) days.

4. Member Services -- The MCO must staff a member services function operated at least during regular business hours and responsible for the following:

a. Orienting the member to the health plan and assisting members in the selection of a PCP;

b. Assisting members to make appointments and obtain services;

c. Assisting in arranging medically necessary transportation for members;

d. Arranging interpreter services;

e. Assisting in reporting fraud, waste, and abuse;

f. Assisting members with coordination of out-of-plan services;

g. Ordering member materials, such as handbooks and provider directories;

h. Explaining to members what to do in an emergency or urgent medical situation;

i. Assisting members with questions regarding benefits and how to access services;

j. Handling members' complaints, grievances, and appeals; and

k. Providing a toll-free telephone number.

5. The MCO must maintain a toll-free member services telephone number. Although the full Member Services function is not required to operate after regular business hours, this or another toll-free telephone number must be staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and weekends, including pharmacy services.

6. Provider Services - The MCO must staff a provider services function operated at least during regular business hours and responsible for the following:

a. Assisting providers with questions concerning member eligibility status and benefits;

b. Assisting providers with plan prior authorization, care coordination, network questions, and referral procedures;

c. Assisting providers with claims payment procedures; and

d. Handling provider complaints.

2.32 Mandatory Participation in Managed Care

Participation in managed care is mandatory for the members of the MACC, non-MAGI and non-Medicaid funded coverage groups identified in § 2.1 of this Part except as specified in § 2.34 of this Part. Medicaid members in these coverage groups with third-party medical coverage or insurance may be exempt from this mandate only as indicated in § 2.38 of this Part, at the discretion of the EOHHS.

2.33 Enrollment Procedures, Rights, and Responsibilities

The enrollment process for MACC groups using the RHP delivery system is set forth in § 2.34 of this Part.

2.34 Enrollment Processes for RIte Care and Rhody Health Partners Managed Care Plans Overview

With the approval of the State's Title XIX, Section 1115 waiver in 2009, enrollment in an MCO became mandatory for all individuals and families covered in the Rhode Island Medicaid program who do not require long term services and supports. The State's goal in implementing this policy is to assure that all Rhode Islanders enrolled in Medicaid have access to an organized system of high quality services that provides a medical home focusing on primary care and prevention services.

2.35 Scope and Purpose

A. The Medicaid eligible Medicaid Affordable Care Coverage (MACC) groups identified in the "Affordable Care Coverage Groups" (Subchapter 00 Part 1 of this Chapter) must enroll for coverage in a RIte Care (families, parent/caretaker, children and pregnant women) or Rhody Health Partners (adults 19-64 without children) managed care plan, as described above. There are other Medicaid coverage groups enrolled in both service delivery systems.

B. This rule applies to all RIte Care coverage groups identified in § 2.1 of this Part. It does not apply to adults eligible on the basis of age, blindness, or disability subject to the provisions for RIte Care unless the beneficiary qualifies for and chooses the eligibility pathway for parents/caretakers. See Part 40-10-1 of this Title for a description of these groups.

C. EOHHS must ensure that enrollment in RIte Care and Rhody Health Partner (RHP) MCOs function in a timely and efficient manner that respects the rights of Medicaid eligible individuals and families and the State's interest in assuring that they have ready access to an organized system of high quality health care.

D. The provisions of this rule also apply to any applicants in these coverage groups who have access to employer-sponsored (ESI) health plans who may be qualified for the RIte Share premium assistance program, as specific in the Medicaid Code of Administrative

Rule “RIte Share Premium Assistance Program (Part 3 of this Subchapter), until further notice from the EOHHS.

2.36 Initiating Enrollment: No Wrong Door

A. The enrollment process begins at the point in which an eligibility determination has been made and the applicant is notified. Once determined eligible, a Medicaid member must select an MCO at the time a determination is made if applying on-line through the web-portal either alone or with assistance. Notice of eligibility provided by EOHHS, whether electronically or on paper, must inform the Medicaid member of whether enrollment in a RIte Care versus Rhody Health Partners plan is required. The Medicaid coverage group that is the basis of eligibility for an individual or family determines the delivery system - RIte Care or RHP - in which a person must enroll (See Medicaid Code of Administrative Rules, "Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways" (Subchapter 00 Part 1 of this Chapter).

1. Enrollment channels --Once determined eligible, a Medicaid eligible person may enroll in a RIte Care or Rhody Health Partners Plan, as appropriate:

a. Online through the eligibility portal independently or with a navigator's assistance;

b. Over the phone with a Contact Center representative; or

c. In-person at the Contact Center or a DHS office. (Contact information located in § 2.67 of this Part).

2. Information on enrollment options - The EOHHS and the RIte Care and RHP MCOs share responsibility for ensuring Medicaid applicants and prospective and current enrollees have access to accurate up-to-date information about their enrollment options. This information is available on-line if applying through the eligibility web portal, as well as through the Contact Center, EOHHS, DHS and the participating MCOs. The information available must include:

a. Materials describing the Medicaid managed care delivery system.

b. A written explanation of enrollment options including information about the applicable service delivery system - RIte Care versus RHP - and choice of participating MCOs therein.

c. Upon requested, an indication of whether a prospective enrollee’s existing physician is a participant in each of the respective MCOs.

d. Non-biased enrollment counseling through the Contact Center or a Navigator.

e. A chart comparing participating MCOs.

f. Detailed instructions on how to enroll.

g. Full disclosure of any time limits and consequences for failing to meet those time limits.

h. Access to interpreter services.

i. Notification in writing of the right to challenge auto-assignment for good cause through EOHHS.

3. Non-biased enrollment counseling -- Non-biased enrollment navigators who are not affiliated with any participating MCO help enrollees choose an MCO and a primary care provider (PCP) capable of meeting their needs. Factors that may be considered when making this choice are whether an existing PCP participates in a particular MCO, as well as language preferences or limitation, geographic proximity, and so forth. Enrollment navigators are available by telephone or in-person at the Contact Center and DHS offices during regular hours of operation. They also are available in-person and by telephone at these locations to assist enrollees who would like to change MCO, such as, during open enrollment or due to good cause).

4. Voluntary selection of MCO -- Prospective enrollees are given fourteen (14) calendar days from the completion of their eligibility determination to select an MCO. All members of a family must select the same MCO. If an individual or family does not select an MCO within the time allowed, the individual or family is automatically assigned to an MCO.

5. Automatic assignment into an MCO -- The State employs a formula, or algorithm, to assign prospective enrollees who do not make a voluntary selection into an MCO. This algorithm considers quality and financial performance.

6. Requests for reassignment - Medicaid enrollees who have selected an MCO voluntarily or have been auto-assigned may request to be reassigned within certain limits. Such requests are categorized as follows:

a. Requests made within ninety (90) days of enrollment. Medicaid members may be reassigned to the MCO of their choice if their oral or written request for reassignment and their choice of an alternative MCO is received by EOHHS within ninety (90) days of the voluntary or auto-assigned enrollment and the MCO selected is open to new members. The effective date of an approved enrollment must be no later than the last day of the second month following the month in which the enrollee requests disenrollment or the MCO requests.

b. Requests made ninety (90) days or more after enrollment. Medicaid enrollees who challenge an auto-assignment decision or seek to change MCOs more than ninety (90) days after enrollment in the health plan must

submit an oral or written request to EOHHS and show good cause, as provided in § 2.48(A)(4) of this Part, for reassignment to another MCO. A written decision must be rendered by EOHHS within ten (10) days of receiving the request and is subject to appeal.

c. Open Enrollment. A Medicaid enrollee may request to be reassigned to another MCO once every twelve (12) months without good cause shown.

7. Auto-assignment and resumption of eligibility - Medicaid members who are disenrolled from an MCO due to loss of eligibility and who regain eligibility within sixty (60) calendar days of disenrollment are automatically re-enrolled, or assigned, into the same MCO if they do not make an MCO selection upon reinstatement of their Medicaid eligibility. If more than sixty (60) days has elapsed and the Medicaid member does not make an MCO selection at the time eligibility was reinstated, the Medicaid member will be auto-assigned to an MCO based on EOHHS's algorithm referenced in § 2.36(A)(5) of this Part.

8. Open-enrollment - To the extent feasible, EOHHS must coordinate open enrollment periods with those established for affordable care more generally through the State's health insurance exchange - HealthSource RI.

9. EOHHS reserves the discretion to provide Medicaid wrap around coverage, as an alternative to coverage in a Medicaid MCO to any eligible individual who has comprehensive health insurance through a liable third party, including (but not limited to) absent parent coverage. Such wrap around coverage must be equivalent in scope, amount and duration to that provided to Medicaid eligible individuals enrolled in in a qualified health plan, including ESI, through the RIte Share program. (Medicaid Code of Administrative Rules, "RIte Share Premium Assistance Program" (Part 3 of this Subchapter).

2.37 Enrollment of Newborns and Adopted Children

A. RHP members remain enrolled in their current plan until the time of renewal or the birth of the child or the end of the pregnancy, whichever comes first.

1. Newborns - Infants born to mothers with income up to 253% of FPL who are enrolled in an MCO on the date of their baby's birth are automatically enrolled into a RIte Care MCO. If the newborn's mother is enrolled in a RIte Care MCO, the child is automatically enrolled in the mother's MCO. If the newborn's mother is enrolled in a RHP MCO, the baby and the mother will be enrolled in a RIte Care MCO, effective on the date of birth, once certification of the birth has been received. If the newborn's mother is enrolled in an ESI or other qualified health plan (QHP) with a Medicaid wrap, the baby is enrolled in RIte Care or RIte Share if the plan meets the cost-effectiveness test set forth in the Medicaid Code of Administrative Rules, "RIte Share Premium Assistance Program" (Part 3 of this Subchapter) See Medicaid Code of Administrative Rules, "Medicaid Affordable

Care Coverage Groups Overview and Eligibility Pathways" (§ 00-1.7(A) of this Chapter) for newborn deeming provisions.

2. Adopted children -- Enrollment of adopted children who are eligible on their own or as part of a Medicaid eligible family also varies depending on the basis of Medicaid coverage. Legally adopted children are enrolled as of the date the adoption becomes final. This date cannot be prior to the date Medicaid eligibility is established. The applicable provisions on eligibility and enrollment of child participating the State's adoption subsidy program are located in, "Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways" (Subchapter 00 Part 1 of this Chapter). A parent, caretaker or guardian must notify EOHHS when a newborn deemed eligible is adopted.

3. Other Infants and Children -- All infants and children with income up to the 261% of the FPL level are Medicaid eligible under the MACC group for children and young adults, irrespective of the eligibility of a parent, caretaker or pregnant mother as indicated in the provisions in, "Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways" (Subchapter 00 Part 1 of this Chapter). Any infants and children determined eligible on this basis are enrolled in a RIte Care or, as applicable, RIte Share-approved ESI health plan in accordance with the provisions of this rule applicable to all other Medicaid members.

2.38 Medicaid Members Exempt from Enrollment Managed Care

A. Certain Medicaid members who would otherwise receive care through the RIte Care or RHP delivery systems may be granted exemptions from mandatory enrollment in an MCO for good cause in narrow range of "extraordinary circumstances" upon approval of EOHHS. An extraordinary circumstance, as defined for these purposes, is a situation, factor or set of factors that preclude a Medicaid member from obtaining the appropriate level of medically necessary care through the managed care delivery system -- RIte Care or RHP - designated for the Medicaid member's coverage group.

1. Types of extraordinary circumstances -- Such a situation, factor or set of factors may include the existence of a chronic, severe medical condition for which the member has a longstanding treatment relationship with a licensed health care practitioner who does not participate in any of the Medicaid MCOs in the delivery system designated to provide care to the member.

2. Limits -- A Medicaid member's preference to continue a treatment relationship with a particular physician or other health care practitioner who does not participate with an MCO in the member's designated delivery system does not constitute an "extraordinary circumstance" in and of itself.

3. Exemption requests - Requests for exemption to mandatory enrollment in managed care due to extraordinary circumstances must be made in writing,

include appropriate documentation (letter from physician, medical records, or other as indicated), and signed. Exemption requests should be routed to EOHHS.

4. Agency actions and duration of exemption -- EOHHS makes enrollment exemption determinations based on a consideration of the circumstances of each member's individual request. Once exempted, an individual can be exempt for as long as the extraordinary circumstance exists. Non-exempt Medicaid members in a household must follow the regular Medicaid MCO enrollment process.

2.39 MCO Lock-In

A. Following initial enrollment into an MCO, Medicaid members are restricted to that MCO until the next open enrollment period. During this health plan lock-in, a Medicaid member may request to be reassigned to another MCO only under one of a set of specific allowed conditions.

1. Allowed conditions for reassignment requests -- Members may request to be reassigned to another MCO for any of the following reasons:

a. Substandard or poor quality care;

b. Inadequate access to necessary specialty services;

c. Lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs;

d. The MCO does not, because of moral or religious objections, cover the services the enrollee seeks;

e. The enrollee needs related services to be performed at the same time; not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

f. Insufficient transportation;

g. Discrimination;

h. Member relocation;

i. Good cause as defined in § 2.48(A)(4) of this Part.

j. Without cause during the ninety (90) days following the effective date of the Medicaid member's initial enrollment with the MCO.

2. Process for requesting reassignment - Medicaid members seeking MCO reassignment during the lock-in period must file a formal request with EOHHS.

3. Agency review -- MCO reassignment can only be ordered by EOHHS after administrative review of the facts of the case. In the course of the review, EOHHS must examine the evidence it has compiled about the grounds that are the basis for the Medicaid member's request for disenrollment.

4. Notice of agency action - EOHHS must provide the member with written notice of the action taken on the request for MCO reassignment. If EOHHS determines that there is sufficient evidence to reassign the Medicaid member, the notice must be sent to the member at least ten (10) days prior to the date the proposed reassignment would be effective. The Medicaid member must submit a plan change form to select another MCO.

2.40 Open Enrollment

During an open enrollment period, Medicaid members have an opportunity to change MCOs. Open enrollment extends to all RHP enrollees and RIte Care enrollees, with the exception of members in the Extended Family Planning coverage group and foster care children who are receiving foster care or adoption subsidy assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement.

2.41 Membership Handbook

The Medicaid MCO must provide a Medicaid enrollee with a membership handbook and information on how to select a primary care provider member. This information must be sent by mail within ten (10) days of the date of enrollment for all members excluding foster children.

2.42 Identification Cards

A. Medicaid members are issued two identification cards - permanent MCO cards and permanent Rhode Island Medicaid cards.

1. MCO permanent cards -- Medicaid MCOs must issue permanent identification cards to all Medicaid members within ten (10) days of the date the enrollment was received by the MCO. The card identifies the MCO name and a twenty-four hour, toll-free telephone number for the Medicaid member to call in the event of an urgent or emergent health care problem. The card also includes the telephone number for the MCO's membership services division and may include the name and telephone number of the recipient's primary care provider.

2. Medicaid cards -- A Rhode Island Medicaid identification card is also issued to Medicaid members who are eligible for out-of-plan benefits through the State's Medicaid Management Information System (MMIS).

2.43 Interim Fee-for-Service Coverage

For RIte Care members only, there is a seven (7) day period between Medicaid MCO assignment and MCO enrollment in which services provided to a Medicaid member may be paid for on a fee-for-service basis. The services must be delivered to the Medicaid member by a health provider or practitioner certified to participate in the RI Medicaid program to qualify for the fee-for service payment. Services delivered prior to MCO enrollment to a pregnant woman who is otherwise ineligible for Medicaid with income above 253% of the FPL are not covered.

2.44 Verification of Eligibility/Enrollment

Medicaid MCO have the opportunity to contact EOHHS, a DHS office, the automated enrollment mailbox utilized by the health plans, or the automated eligibility verification system as necessary and appropriate to verify eligibility and plan enrollment if a Medicaid member requires immediate services.

2.45 Responsibility of Medicaid Members to Report Change in Status

Medicaid members are responsible for reporting certain changes in status including any related to family size, residence, income, employment, third party coverage, and child support. Such information must be filed with EOHHS, the Contact Center or a DHS field office within ten (10) days of the date the change occurs. In addition, EOHHS conducts periodic reviews to determine whether any changes in status have occurred that affect eligibility or health plan enrollment. Medicaid MCOs must also report to EOHHS any changes in the status of Medicaid members once they become known.

2.46 Transitioning Members between MCOs and Delivery Systems

A. It may be necessary to transition a Medicaid member between MCOs or from one delivery system -- RHP to RIte Care or vice versa -- for a variety of reasons:

1. Change in MCOs within a delivery system - The transition between Medicaid MCOs may occur as a result of change in MCO during open enrollment or a change that is ordered as part of a grievance resolution. The MCOs have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when transitioning a member to or from another MCO. The MCO must transfer this information at no cost to the member.

2. Change in delivery systems - Medicaid members may be transitioned from one managed care delivery system into another as a result of changes in eligibility status. Adults enrolled in RIte Care who are between the ages of 19 and 64 may be eligible under the MACC group for adults when their dependent children age out of MACC group for children and young adults. Once a RHP member has given birth, both newborn and/or parents may be transitioned to RIte Care if income is within the eligibility thresholds set forth in "Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways" (Subchapter 00 Part 1 of this Chapter). Enrollment in MCOs during such transitions will strive to preserve

the continuity of care to the full extent feasible. Accordingly, Medicaid members enrolled in a particular MCO subject to a delivery system transition will be enrolled in the same health plan, if participating, in the new delivery system.

2.47 Grievances, Appeals, and Hearings

The State provides a grievance and appeals process that MCO providers and Medicaid enrollees must use when seeking redress against health plans. This is the same process that the MCOs must use when seeking to disenroll members who are habitually non-compliant or who pose a threat to plan employees or other members. Part 10-05-2 of this Title, "Appeals Process and Procedures for EOHHS Agencies and Programs" for additional information.

2.48 MCO Initiated Disenrollment

A. The MCO may seek disenrollment of a member who is habitually non-compliant or poses a threat to MCO employees or other members. An MCO initiated disenrollment, is subject to an administrative review process by EOHHS and must follow the following requirements:

1. MCO disenrollment requests -- For an MCO to disenroll a Medicaid member, the MCO must send a request, along with accompanying documentation, to EOHHS. When the request is received, EOHHS sends a notice to the Medicaid member informing him or her that the MCO is seeking to take a disenrollment action and explaining the reason given by the MCO for taking such an action. The notice also informs the member that of the right to submit within ten (10) days any evidence establishing a good cause appeal rejecting the disenrollment action.

2. Additionally, the MCO must:

a. Specify the reasons for which the MCO is requesting disenrollment of an enrollee;

b. Not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this particular enrollee or other enrollees).

c. Specify the methods by which the MCO assures EOHHS that it does not request disenrollment for reasons other than those permitted under the managed care contract.

3. EOHHS action -- EOHHS must investigate and render a decision within ten (10) days of receipt of evidence from both parties. EOHHS's decision is subject to appeal. If, based upon the evidence submitted by the health plan, EOHHS

determines that the Medicaid member should be disenrolled from the health plan, a notice is sent to the Medicaid member by EOHHS stating the decision and the basis thereof at least ten (10) days prior to the date the proposed disenrollment would be effective.

4. Good Cause appeal -- A Medicaid member subject to a health plan request for disenrollment has the right to present evidence establishing good cause. Good cause must be filed prior to the end of the ten (10) day advance notice period. The filing of good cause is submitted in writing to EOHHS. Good cause includes circumstances beyond the Medicaid member's control sufficiently serious to prevent compliance; an unanticipated household emergency; a court-required appearance; incarceration; breakdown in transportation arrangements; or inclement weather which prevented the Medicaid member and other persons similarly situated from traveling to, or participating in, the required appointment. A member's preference to remain in fee-for-service does not constitute good cause for an appeal of the request for disenrollment.

2.49 EOHHS Authority

EOHHS has sole authority as the Medicaid Single State Agency for disenrolling Medicaid members from an MCO. Requests for disenrollment, either as the result of a formal grievance filed by the Medicaid member against the MCO, or by the MCO against the Medicaid member, is subject to an administrative review process by EOHHS.

2.50 Reasons for Disenrollment

A. EOHHS may disenroll Medicaid eligible MCO members for a variety of reasons including, but not limited to, any of the following:

1. Death;

2. Loss of eligibility;

3. Selection of another MCO during open enrollment;

4. Change of residence outside of the MCO's service area;

5. Non-payment of premium share;

6. Incarceration;

7. Permanent placement in Eleanor Slater Hospital;

8. Long-term placement in a nursing facility for more than thirty (30) days (does not apply to RIte Care members);

9. Disenrollment as the result of a formal grievance filed by the member against the MCO; or

10. Disenrollment as the result of a formal grievance filed by the MCO against the member.

2.51 Disenrollment Effective Dates

Member disenrollments outside of the open enrollment process become effective on the date specified by EOHHS, but not fewer than six (6) days after the MCO has been notified, unless the MCO waives this condition. The MCOs have written policies and procedures for complying with EOHHS disenrollment orders.

2.52 Right to Appeal

All notifications of disenrollment must include information regarding the Medicaid member's right to appeal the decision and the procedures for requesting an EOHHS administrative fair hearing.

2.53 Medicaid Member Rights and Protections

A. All Medicaid members are guaranteed access to quality health care delivered in a timely and respectful manner. To ensure this goal is met, the following rights and protections must be clearly stipulated by both EOHHS and the MCO.

1. Enrollment -- EOHHS will make every effort to provide the following:

a. Multilingual services to all people who do not speak English;

b. Written enrollment information will be provided in a clear and easy-to-understand format;

c. Enrollment information provided by the MCO must include detailed information on how to obtain transportation services, second opinions, interpreter services, referrals, emergency services and out-of-state services unavailable in Rhode Island. Information must also be provided regarding switching primary care providers, disenrollment for good cause, the in-plan grievance process and the EOHHS appeals process;

d. The State will conduct a special enrollment outreach effort for beneficiaries who are homeless or who live in transitional housing;

e. Once a Medicaid member is enrolled, the MCO will conduct a special enrollment outreach effort for any enrollees who are homeless or who live in transitional housing;

f. The MCO is prohibited from engaging in any door-to-door or telemarketing or any other similar unfair marketing practices;

g. Enrollees will be provided with counseling assistance in the selection process for their primary care providers;

h. Medicaid members who receive on-going care from a primary care provider or specialist will be advised by the non-biased enrollment counselor which providers are participating in each MCO option so as to promote continuity of care;

i. If a Medicaid member is auto-assigned to an MCO, the member, within ninety (90) days, may dispute that assignment through the right to rebuttal. A decision by EOHHS must be rendered within ten (10) days of the filing of the rebuttal and is subject to appeal.

2. Second Opinions and Switching Doctors - Every Medicaid member must be informed of the following:

a. MCOs must provide, at their expense, a second opinion within the MCO upon an enrollee's request. A decision on the request for a second opinion will be made in a timely manner and approval shall not be unreasonably withheld;

b. A Medicaid member is entitled to a second surgical opinion by a plan physician, or if the referral is made by a plan physician, to a second surgical opinion by a non-participating physician;

c. Medicaid members have the right to switch providers within the MCO, upon request.

d. Members who are denied a second opinion or denied the right to switch providers will have the right to appeal, as set forth in Part 10-05-2 of this Title, "Appeals Process and Procedures for EOHHS Agencies and Programs" for additional information.

3. Disenrollment - The following apply to requests for disrenrollment, as indicated:

a. Medicaid members may request to disenroll from any MCO for the remainder of an enrollment period for any of the reasons established in § 2.34 of this Part;

b. A rapid disenrollment process must be provided for individuals and families who are dislocated and move to another area due to homelessness, domestic abuse, or other similar crises, if they cannot access in-plan services within a reasonable distance from their new location;

4. Interpreter Services --Plans are encouraged to provide availability to twenty-four (24) hour interpreter services for every language group enrolled by the health plan for all points of contact, especially telephone contact. In addition, reasonable

attempts must be made by the plans to have written materials, such as forms and membership manuals, translated into other languages. If the health plan has more than fifty (50) members who speak a single language, it must make available general written materials, such as its member handbook, in that language. Interpreter services are provided if a plan has more than one hundred (100) members or ten percent (10%) of its Medicaid membership, whichever is less, who speak a single language other than English as a first language.

a. Written material must be available in alternative formats, such as audio and large print, and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services. All enrollees must be informed that information is available in alternative formats and how to access those formats.

5. Exceptions Based on Safety Needs -- Providers, MCOs and the State must consider the personal safety of a beneficiary in instances of domestic violence in all of the following matters:

a. Enrollment policies;

b. Disenrollment policies;

c. Second opinions;

d. Switching primary care physicians/practitioners; and

e. Grievance procedures.

6. Referral to Rhode Island Legal Services -- Notices to Medicaid members must include information indicating that they may represent themselves or be represented by someone else such as a lawyer, relative, or another person in the hearing and appeal process. Notices must also provide information regarding free legal help available at Rhode Island Legal Services.

2.54 Pharmacy Home Program

A. The objective of the Pharmacy Home Program is to prevent members from obtaining excessive quantities of prescribed medications through visits to multiple prescribers and pharmacies and improving health outcomes. Participants enrolled in the program are required to obtain all medications from a specific pharmacy location otherwise known as a “Pharmacy Home” for a period of two (2) years.

B. The EOHHS, or its contracted MCO, will establish criteria to identify members for inclusion in the Pharmacy Home Program. Members will be notified at least thirty (30) days prior to enrollment in the program.

C. Select provider referrals are available as part of the Pharmacy Home Program. The EOHHS, or its contracted MCO, will ensure that members with complex medical and/or behavioral health needs are connected with high quality select providers to meet those needs. Members who use multiple providers and have one or more complex medical conditions and chronic diseases shall be referred as needed to a select provider.

2.55 Rite Smiles Dental Plan Overview

A. The RIte Smiles Program is a statewide dental benefits managed care delivery system established under a federal waiver. The program's goal is to improve access to oral health services for Rhode Island children who receive Medicaid. Emphasis is placed on preventive and primary care dental services and education.

B. Children born on or after May 1, 2000 who are receiving dental benefits through Medicaid are enrolled in a RIte Smiles dental plan. EOHHS contracts with one or more dental plans to provide oral health services to these Medicaid-eligible children.

2.56 Legal Authority

Title XIX of the Social Security Act provides the legal authority for the Medicaid Program. The RIte Smiles Program operates under a waiver under the authority of Section 1115 of the Social Security Act.

2.57 Coverage Groups

A. Participation in the RIte Smiles Program is mandatory for all children in the following populations who were born on or after May 1, 2000 and who are receiving Medicaid:

1. Section 1931 children and related populations (including poverty level groups and RI Works cash recipients);

2. Blind and/or disabled children;

3. Foster care children who are receiving foster care or adoption subsidy assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement;

4. Section 1115 Waiver Children.

2.58 Excluded Coverage Groups

A. The following groups are excluded from participation in the RIte Smiles Program:

1. Children born on or before April 30, 2000;

2. Children who have access to third party dental benefits;

3. Children who reside in nursing facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID).

4. Children who reside outside of the State of Rhode Island. Those children who are not eligible to participate in the RIte Smiles Program receive dental benefit coverage under the fee-for-service system.

2.59 Retroactive Eligibility

If a member is eligible for retroactive eligibility, the dental plan does not provide coverage to Medicaid beneficiaries during the period of retroactive eligibility.

2.60 Enrollment Process

A. All children determined eligible for Medicaid who were born on or after May 1, 2000 must enroll in a RIte Smiles Program dental plan. The parent(s) or guardian(s) of the eligible children may have a choice of dental plans, if more than one plan is available, in which to enroll.

B. The enrollment process insures that applicants/beneficiaries are provided with sufficient information (if a choice of dental plan is available) in order to make an informed choice when deciding upon which RIte Smiles plan to choose.

2.61 Voluntary Selection of a Dental Plan

Newly eligible children for RIte Care, RIte Share, or fee-for service Medicaid will be given a choice of RIte Smiles plans on their Medicaid application.

2.62 Auto Re-Enrollment Following Resumption of Eligibility

Members of families who receive Medicaid and who are disenrolled from a dental plan due to loss of eligibility are automatically re-enrolled, or assigned, into the same plan should they regain eligibility within sixty (60) calendar days. If more than sixty (60) days has elapsed, the family is permitted to select a plan from those open for enrollment at that time.

2.63 Rite Smiles Lock-In

A. After initial enrollment into a RIte Smiles plan, enrollees are restricted to that dental plan until the next open enrollment period, unless disenrolled under one (1) of the conditions described below:

1. Loss of Medicaid eligibility, including for non-payment of applicable premium shares for RIte Care or RIte Share;

2. Selection of another dental plan during open enrollment, if another plan exists;

3. Death;

4. Relocation out-of-state;

5. Adjudicative actions;

6. Change of eligibility status;

7. Eligibility determination error;

8. As the result of a formal grievance filed by the member against the dental plan or by the dental plan against the member;

9. Just cause (as determined by EOHHS).

2.64 Open Enrollment

During open enrollment members have an opportunity to change RIte Smiles dental plans, if more than one dental plan is available.

2.65 Voluntary Disenrollment

A. RIte Smiles members seeking disenrollment during the lock-in period must first file a formal appeal pursuant to appeal procedures with the dental plan (with the exception that members are permitted to disenroll without cause during the ninety (90) days following the effective date of the individual's initial enrollment, if more than one dental plan is available).

B. Disenrollment can only be ordered by EOHHS after administrative review of the facts of the case. In order for disenrollment to occur, EOHHS must first find in favor of the member, and then determine that the appropriate resolution to the member's complaint is the member's disenrollment.

2.66 Member Disenrollment

A. Unless the member's continued enrollment in the dental plan seriously impairs the dental plan's ability to furnish services to either the particular member or other members, a RIte Smiles dental plan may not request disenrollment of a member because of:

1. An adverse change in the member's health status;

2. The member's utilization of medical/dental services; or

3. Uncooperative or disruptive behavior resulting from the member's special needs. All disenrollments are subject to approval by EOHHS.

2.67 Information and Referral

A. For Further Information or to Obtain Assistance:

1. www.eohhs.ri.gov

2. www.dhs.ri.gov

3. www.HealthSourceRI.com

B. 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 1-855-609-3304 and TTY 1-888-657-3173.

C. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

2.68 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.

Chapter 30 - Medicaid for Children, Families, and Affordable Care Act (ACA) Adults

Subchapter 05 - Service Delivery Options

RIte Share Premium Assistance Program (210-RICR-30-05-3)

3.1 Overview / Legal authority

Under the terms of Section 1906 of Title XIX of the U.S. Social Security Act, states are permitted to pay an eligible individual's share of the costs for enrolling in employer-sponsored health insurance coverage if it is cost effective to do so. R.I. Gen. Laws § 40-8.4-12 authorized the Medicaid agency to establish the RIte Share Premium Assistance Program to subsidize the costs of enrolling Medicaid eligible individuals and families in employer-sponsored health insurance (ESI) plans that have been approved as meeting certain cost and coverage requirements. The Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, uses cost-effective criteria to determine whether ESI plans meet these requirements.

3.2 Scope and Purpose

A. This Part applies to individuals and families determined to be Medicaid eligible under Section 1301, "Coverage Groups" (Medicaid Affordable Care Coverage "MACC" groups). It also applies to specified individuals determined to be Medicaid eligible under Part 2 of this Subchapter (non-MAGI or non-Medicaid funded). If these individuals or families have access to insurance provided through an employer (ESI), EOHHS must conduct a review of the coverage to determine if the benefits are comparable to Medicaid benefits and if the cost of the ESI is less expensive than full Medicaid coverage. When ESI is found to be cost-effective, the State will pay the employee's premium.

B. The purpose of this rule is to set forth the provisions governing participation in the RIte Share Program, the buy-in requirement and the process for determining whether an ESI plan meets the cost-effectiveness criteria established by EOHHS, the Medicaid agency. The rule also identifies the respective roles and responsibilities of Medicaid-eligible individuals and families and the Medicaid agency.

3.3 Definitions

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

1. "Applicant" means a person seeking Medicaid coverage under this Part, in accordance with the provisions established in Rhode Island General Laws and Public Laws.

2. “Cost-effective” means that the portion of the ESI that the State would subsidize, as well as wrap-around costs, would, on average, cost less to the State than enrolling that same individual/family in a managed care delivery system.

3. “Cost-sharing” means any co-payments, deductibles or co-insurance associated with ESI.

4. “Employee premium” means the monthly premium share an individual or family is required to pay to the employer to obtain and maintain ESI coverage.

5. “Employer-Sponsored Insurance” or “ESI” means health insurance or a group health plan offered to employees by an employer. This includes plans purchased by small employers through HealthSource RI.

6. “Group health plan” means an employee welfare benefits plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 as qualified in R.I. Gen. Laws §§ 27-50-3(T)(1) and 27-18.6-2(15).

7. “Health insurance coverage” or “health benefit plan” means a policy, contract, certificate or agreement offered by a health insurance carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services as defined and qualified in R.I. Gen. Laws §§ 27-18.5-2(7), 27-18.6-2(14) and 27-50-3(U)(1).

8. “Medicaid member” means a person who has been determined to be an eligible Medicaid beneficiary.

9. “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. Social Security benefits are not included in gross income. The MAGI is the standard for determining income eligibility for all Medicaid affordable care coverage groups (MCAR Section 1301, “Coverage Groups”).

10. “Policy holder” means the employee with access to ESI.

11. “RIte Share-approved employer-sponsored insurance” or “ESI” means an employer-sponsored health insurance plan that meets the coverage and cost-effectiveness criteria for RIte Share.

12. “RIte Share buy-in” means the monthly amount a parent or caretaker of a Medicaid-eligible child or young adult must pay toward RIte Share-approved ESI that covers the parent or caretaker with access to the ESI and his/her Medicaid-eligible children. The buy-in only applies in instances when household income based on the MAGI is above 150% of the Federal Poverty Level (FPL).

13. “RIte Share Premium Assistance Program” means the Rhode Island Medicaid premium assistance program in which the State pays the eligible Medicaid member’s share of the cost of enrolling in a RIte Share-approved ESI plan. This

allows the State to share the cost of the health insurance coverage with the employer.

14. “RIte Share Unit” means the entity within EOHHS responsible for assessing the cost-effectiveness of ESI, contacting employers about ESI as appropriate, initiating the RIte Share enrollment and disenrollment processes, handling member communications, and managing the overall operations of the RIte Share program.

15. “RIWorks” means the State’s Temporary Assistance for Needy Families (TANF) program that provides assistance to low income needy families on the path to full employment and financial independence. The program is administered by the Rhode Island Department of Human Services, one of the four State agencies under the Executive Office of Health and Human Services (EOHHS) umbrella.

16. “Third party liability” or “TPL” means other health insurance coverage. This insurance is in addition to Medicaid and is usually provided through an employer. Since Medicaid is always payer of last resort, the TPL is always the primary coverage.

17. “Wrap-around services or coverage” means any health care services not included in the ESI plan that would have been covered had the Medicaid member been enrolled in a RIte Care or Rhody Health Partners plan (Part 2 of this Subchapter). Coverage of deductibles and co-insurance is included in the wrap. Co-payments to providers are not covered.

3.4 RIte Share Populations

A. The income of Medicaid members affects whether and in what manner they must participate in RIte Share as follows:

1. Income at or below 150% of FPL - Individuals and families determined to have household income at or below 150% of the Federal Poverty Level (FPL) based on the modified adjusted gross income (MAGI) standard - in accordance with MCAR Section 1307, “Determination of Income Eligibility” - are required to participate in RIte Share if a Medicaid-eligible adult or parent/caretaker has access to cost-effective ESI. Enrolling in ESI through RIte Share is a condition of maintaining Medicaid eligibility. The buy-in requirement described in § 3.8 of this Part does not apply, however.

2. Income above 150% FPL and policy holder is not Medicaid-eligible - Premium assistance is available when the household includes Medicaid-eligible members, but the ESI policy holder, typically a parent or caretaker, is not eligible for Medicaid. Premium assistance for parents/caretakers and other household members who are not Medicaid-eligible is provided when:

a. Enrollment of the Medicaid-eligible family members in the approved ESI plan is contingent upon enrollment of the ineligible policy holder; and

b. It is cost-effective to provide a subsidy to family coverage compared to the cost of enrolling Medicaid eligible family members in a Medicaid managed care plan, using methodology described in § 3.8 of this Part.

3. Medicaid-eligible children and young adults - Eligible children and young adults remain eligible for Medicaid if the person with access to RIte Share-approved ESI does not enroll as required.

3.5 RIte Share Enrollment as a Condition of Eligibility

A. For Medicaid members over the age of nineteen (19), enrollment in RIte Share is a condition of eligibility. This requirement also applies to any individuals who have or previously had the option to waive ESI coverage to receive financial compensation, including but not limited to, an increase in hourly wage, an increase in weekly salary, and/or a lump sum payment. (An increase in wages for waiving coverage is also known as "pay in lieu of benefits.")

1. Exemptions - In certain circumstances, Medicaid members with access to ESI are exempt from enrolling as condition of maintaining eligibility:

a. Under age 19. Medicaid-eligible children and young adults up to age nineteen (19) are not required to enroll in a parent/caretaker relative's ESI as a condition of maintaining Medicaid eligibility.

b. RIWorks. There is a limited six (6) month exemption from the mandatory enrollment requirement for RIWorks program participants. See § 3.5 of this Part below.

c. Pregnant women.

2. Mandatory ESI Enrollment - Once it has been determined by EOHHS that the ESI offered by a particular employer is RIte Share-approved, all Medicaid members with access to that employer's plan are required participate in RIte Share. If the policy holder, that is, an employee in the household, is a Medicaid-eligible parent/caretaker age nineteen (19) or older, the policy holder is responsible for enrolling any Medicaid-eligible family members (spouse, caretaker, and children) in the RIte Share-approved ESI plan.

3. Non-compliance - Failure to meet the mandatory enrollment requirement results in the termination of the Medicaid eligibility of the policy holder and other Medicaid members nineteen (19) or older in the household that could be covered under the ESI until the policy holder complies with the RIte Share participation and enrollment procedures established by EOHHS in this rule. (See § 3.20 of this Part).

4. Reinstatement - The period of ineligibility may be shortened and Medicaid eligibility reinstated if the policy holder complies with RIte Share's request to enroll in ESI, or if participation in RIte Share by the policy holder is no longer required either due to a change in the status of the ESI, such as the employer's plan is no longer RIte Share-approved, or access to the employer's plan, such as, the policy holder changes jobs or is no longer qualified for ESI as a result of a decrease in work hours.

3.6 Rhode Island Works Participants

A. RIWorks participants who are Medicaid-eligible are not required to enroll in a RIte Share-approved ESI plan for the first six (6) months of employment. This six month exemption also applies to families losing eligibility for RIWorks due to employment. Specifically, to be subject to enrollment in a RIte Share approved ESI plan, the RIWorks participant must be:

1. Age nineteen (19) or older; and

2. Employed for a period of six (6) consecutive months or more by the same employer.

B. RIWorks participants who do not meet both of these criteria at the time Medicaid eligibility is renewed in accordance with § 3.16 of this Part are exempt from participating in RIte Share.

3.7 RIte Share Premium Assistance

A. Under the RIte Share Premium Assistance Program, the State pays the policy holder's premium. In some cases, the State will also pay for cost-sharing requirements. Medicaid members also receive wrap-around services.

1. Premium payments - EOHHS pays for ESI premiums as follows:

a. EOHHS pays the premium the policy holder must pay to the employer for ESI for his or her own individual coverage, such as a parent/caretaker who is a pregnant woman.

b. EOHHS pays the premium the policy holder must pay to the employer for ESI for family/dependent coverage. See § 3.17 of this Part.

2. Cost-sharing - Medicaid beneficiaries enrolled in ESI are not obligated to pay any cost-sharing that is not otherwise applicable to Medicaid. EOHHS pays for any ESI co-insurance and deductibles in such instances. Co-pays are not covered by EOHHS, but RIte Share enrollees are not required to pay co-payments to Medicaid certified providers. The health care provider may not bill the RIte Share member for any cost-sharing required by the ESI, including co-payments.

3. Wrap-around coverage - Services and benefits that are covered by Medicaid, but are not offered through the ESI plan, are made available through the Medicaid program. Wrap-around services/coverage ensures that RIte Share enrollees receive health coverage comparable in scope, amount and duration to Medicaid members enrolled in RIte Care or Rhody Health Partners. Medicaid covers these services for Medicaid members participating in RIte Share enrollees when using Medicaid providers.

4. Repayment and recoupment - EOHHS has the authority to recover Medicaid benefit overpayment claims and cost-share arrearages through offset of the individual State income tax refund in accordance with R.I. Gen. Laws §§ 44-30.1-1, 44-30.1-3, 44-30.1-4 and 44-30.1-8 in Chapter 44-30.1 entitled 'Setoff of Refund of Personal Income Tax.'

3.8 RIte Share Buy-in Requirement

A. In certain instances, Medicaid beneficiaries participating in RIte Share are subject to a buy-in requirement. This requirement applies only when a Medicaid-eligible child is residing in a household with MAGI-based income above 150% of the FPL and must enroll in the RIte Share-approved ESI plan of a parent/caretaker - "the policy holder" - who is not eligible for Medicaid.

1. Buy-in amount - The parent/caretaker is required to pay a monthly buy-in amount that varies with income as follows:

Monthly Family Income	Monthly Buy-In Amount
Over 150% and not greater than 185% FPL	$ 61.00
Over 185% and not greater than 200% FPL	$ 77.00
Over 200% and not greater than 250% FPL	$ 92.00

2. Notice - EOHHS must provide the adult in the family subject to the buy-in requirement with timely notice. This may be done separately or in conjunction with the notice of RIte Share participation. The notice must include the amount of the buy-in, the process for making payments, the consequences for non-payment and a statement of the right to appeal and request a hearing.

3. Payment - Buy-in amounts are not prorated. Therefore, a full monthly buy-in amount is due if RIte Share enrollment is effective for any portion of a coverage month.

4. Method of payment - The parent/caretaker pays the monthly RIte Share buy-in amount to EOHHS. Further information about the payment method is provided in the notice of the buy-in requirement sent to the parent/caretaker.

5. Non-compliance - If the parent/caretaker fails to pay the buy-in amount as required, eligibility may be terminated for failing to cooperate in accordance with § 3.22 of this Part. Children and young adults in the family who are eligible for Medicaid will be enrolled in a RIte Care plan. Only individuals over age nineteen (19) are subject to the disenrollment sanction.

3.9 Basis for Approving ESI Plans

A. Only ESI or group health plans that meet the cost-effectiveness and benefits criteria specified in this Part are approved for the RIte Share Premium Assistance Program.

1. Sources of information for determining cost-effectiveness - Determinations of ESI cost-effectiveness is based on information gathered from the following sources:

a. Application materials. When applying for Medicaid, applicants must indicate: current health insurance coverage status; relationship to policy holder; plan name; policy number; eligibility for and type of coverage and individuals covered by the plan. MCAR section 1303, "Application Process," explains the process for applying for Medicaid through the State's affordable care eligibility system and the manner in which this information is collected and maintained.

b. The RIte Share Unit. This EOHHS Unit collects employer data about ESI plans for Medicaid-eligible individuals/households. Information from employers includes data necessary to determine whether the employer's ESI offerings meet EOHHS's cost-effectiveness and benefits criteria.

2. EOHHS reserves the right to request additional information about the ESI plan from the Medicaid beneficiary, the policy holder, even if not an eligible Medicaid member and, where appropriate and necessary, the employer or insurance carrier.

3.10 Methodology for Determining Cost-Effectiveness

A. The RIte Share Unit uses the information about the ESI plan to compare the enrollment cost, that is, payment of the employee's share, for the Medicaid members in the family, and any ineligible policy holder, in a Medicaid managed care plan versus RIte Share. An ESI plan is determined to be cost-effective when on the aggregate, the total cost of medical coverage through RIte Share is less than the average cost to cover them through a Medicaid managed care plan. RIte Share participants receive coverage comparable in scope, amount, and duration to coverage provided in a Medicaid managed care plan.

1. Cost-effectiveness test - To be cost-effective, the policy holder's monthly ESI premium share, deductibles, co-insurance plus any Medicaid covered services not covered by the ESI plan, such as services covered under the RIte Care Health Plan contract but not under the ESI plan) must be less than the average capitation

payment for an average individual/family enrolled in a Medicaid managed care plan. These average costs must be actuarially determined at such intervals as deemed appropriate by EOHHS.

2. There are three cost effectiveness determinations for each employer plan:

a. Family coverage where all family members are Medicaid-eligible with income less than or equal to 133% of the FPL based on the MAGI standard;

b. Family coverage where only children and pregnant women in the family are Medicaid eligible with income greater than 133% of the FPL and less than or equal to 250% of the FPL based on the MAGI standard; and

c. Individual coverage where only the employee is Medicaid-eligible such as pregnant women.

B. The figures used as the basis for assessing cost-effectiveness shall be made available, upon request, by EOHHS.

3.11 Scope and Consequence of Approving an ESI Plan

RIte Share-approved ESI plans are reevaluated on an annual basis to ensure that all Medicaid beneficiaries who are enrolled receive coverage comparable in scope, amount, and duration to that provided in a Medicaid managed care plan. From the date an ESI plan is approved until the date it is reevaluated, any Medicaid beneficiaries who work for that employer, and their Medicaid-eligible dependents, must enroll in the ESI through RIte Share. Parents/caretakers of a Medicaid-eligible child who have access to a RIte Share-approved ESI plan must enroll the child in the plan irrespective of their own Medicaid eligibility. In either case, failure of the parent/caretaker to enroll in the RIte Share-approved plan does not affect the eligibility of the child.

3.12 Enrollment Process

A. Medicaid beneficiaries who are required to participate in RIte Share must enroll in the ESI plan as directed by EOHHS. Enrollment into RIte Share may occur upon initial determination or at the time of Medicaid annual renewal, or as deemed appropriate by EOHHS. Enrollment in RIte Share is deemed to be a “qualifying event” and may occur at any time, including outside the open enrollment period.

1. Eligibility determination and RIte Share referral - The referral for RIte Share participation is based on information provided by the Medicaid beneficiary in conjunction with an initial Medicaid application or annual Medicaid renewal; and documented in the EOHHS database as to whether an employer offers RIte Share-approved coverage.

2. Notice RIte Share participation required - A notice must be sent by EOHHS indicating that participation in RIte Share is a condition of retaining Medicaid eligibility as follows:

a. Fourteen days' notice. Upon determining that a Medicaid member is qualified for coverage through RIte Share, EOHHS provides a written "Notification of Eligibility for Enrollment" stating the employee must select a RIte Share-approved ESI plan through their employer's personnel or human resources office within fourteen (14) calendar days.

b. Thirty days' notice. Written notice will be sent to the Medicaid beneficiary approximately thirty (30) days prior to the date that enrollment in RIte Share is required, but only in instances when approval of the ESI plan is the impetus for the requirement to enroll rather than a determination/renewal of Medicaid eligibility; and the employer is not participating in RIte Share.

3. Prior agreement - In certain circumstances, EOHHS may have a prior agreement with the employer which permits the RIte Share Unit to enroll an eligible individual/family in the ESI plan upon receipt of an acknowledgment or written consent from the policy holder. The notification of enrollment sent from the RIte Share Unit to the Medicaid-ineligible policy holder as well as to any Medicaid recipients in such cases shall explain any such prior arrangements and any additional appeal and hearing rights that follow therefrom.

3.13 Access to ESI

A. All Medicaid applicants and beneficiaries are required to provide information about access to ESI. For the purposes of RIte Share, "access" to ESI is as follows:

1. A Medicaid-eligible individual, age nineteen (19) or older who is, or has the option to be, enrolled in an employer-sponsored health insurance or group health benefit plan;

2. A Medicaid-eligible individual who is, or has the option to be, enrolled in an employer-sponsored health insurance or group health benefit plan as the spouse, dependent or family member of a Medicaid-ineligible policy holder.

B. Failure to provide this information as required may lead to the denial or termination of Medicaid eligibility, unless there is good cause for non-compliance as specified in § 3.23 of this Part.

3.14 Non-custodial Parents with TPL

A. Medicaid is always the payer of last resort. Accordingly, EOHHS considers all other health insurance or coverage provided to a Medicaid-eligible individual as third-party liability (TPL) coverage. EOHHS reserves the right to require Medicaid beneficiaries to

transition to the TPL coverage in instances it meets the cost and coverage effectiveness criteria for RIte Share. Special rules for handling this transition when a parent who does not have custody of the Medicaid-eligible child has access to ESI or other TPL are as follows:

1. TPL coverage through the non-custodial parent - Children who are enrolled in both RIte Care and ESI through a non-custodial parent (NCP), will be transitioned into RIte Share unless the custodial parent shows good cause for not making the transition. Once enrolled in TPL coverage, the child must retain access to all applicable Medicaid covered services the entire time that they are in RIte Share. Should the NCP lose their ESI, the RIte Share Unit must be notified at least ten (10) days prior to the child's disenrollment to meet established reporting requirements and assure the child is transitioned back into RIte Care without coverage gaps.

2. Custodial parent non-compliance - If the custodial parent refuses to allow the child to be enrolled in the NCP's ESI or TPL coverage more generally, then the custodial parent's Medicaid eligibility is terminated until the parent complies with the RIte Share participation requirement. Good cause exemptions to RIte Share are permitted under § 3.23 of this Part.

3. Notice and enrollment - Medicaid beneficiaries who are potential candidates for RIte Share must be provided with notice from EOHHS explaining their rights and responsibilities including:

a. RIte Share participation. The requirement to participate in RIte Share is a condition of Medicaid eligibility for adults in the household. The Medicaid member with TPL must receive the notice fourteen (14) or thirty (30) days, as appropriate (see § 3.11 of this Part), prior to the required transition from a Medicaid managed care plan.

b. Grace period. Parents/caretakers are given a fourteen (14) day grace period to report any changes in the NCP's coverage and/or report any difficulties with using the NCP's coverage.

c. Failure to respond. If the parent/caretaker does not respond, the Medicaid beneficiaries who are covered under the NCP's policy will be transitioned from RIte Care to RIte Share, and sent appropriate documentation. Those who are not covered under the NCP's coverage, such as a custodial mom, children not related to the NCP, will remain on RIte Care.

d. Cost-sharing. The notification must indicate clearly that EOHHS will not make payment for coinsurance, cost sharing obligations, or wrap-around coverage to or for the NCP policy holder or any other Medicaid-ineligible family member/dependent enrolled in the approved ESI plan.

e. Buy-in. If income is above 150% of the FPL, the notice must state the basis for the buy-in and the amount that must be paid per month in accordance with § 3.7 of this Part and the consequences for non-compliance in § 3.22 of this Part.

3.15 Continuing Eligibility - Medicaid Renewals

A. For Medicaid beneficiaries renewing eligibility, EOHHS must assess as part of the redetermination process whether anyone in the household is a RIte Share participant and if there has been any change in access to ESI.

1. Notice of renewal - Medicaid beneficiaries must be provided with a notice at the time of renewal specifying the terms for continuing eligibility. The terms for continuing coverage vary as follows:

a. Medicaid managed care enrollees without access to ESI continue enrollment in the Medicaid managed care plan that provided coverage in the previous period of eligibility in accordance with Part 2 of this Subchapter.

b. Medicaid managed care enrollees who have gained access to a RIte Share-approved ESI plan continue to be enrolled in the Medicaid managed care plan that provided coverage in the previous period of eligibility pending review by the RIte Share Unit. In such cases, EOHHS sends a notice stating that eligibility is continued and that coverage in a Medicaid managed care plan continues pending action on the ESI plan by the RIte Share Unit. A referral to the RIte Share Unit is made accordingly.

c. RIte Share participants who retain access to the RIte Share-approved ESI plan that provided coverage during the during the previous period of eligibility, continue to be enrolled in the ESI plan pending review by the RIte Share Unit of any changes that might result in withdrawal of approval of the ESI plan, disenrollment, and subsequent enrollment in a Medicaid managed care plan.

2. Loss of ESI - RIte Share participants who involuntarily lose access to an approved ESI plan that provided coverage during the previous period of eligibility for any of the reasons stated in § 3.21 of this Part receive coverage as follows:

a. Any Medicaid-eligible individuals in the family will receive coverage through fee-for-service pending either enrollment in a Medicaid managed care plan, or if the Medicaid members have gained access to another ESI plan, approval of that plan by the RIte Share Unit.

3. Notice of renewal - In all such cases, the notice of renewal for continuing eligibility sent by EOHHS to the Medicaid beneficiaries shall include a statement of the applicable terms for continuing eligibility including any buy-in

requirement, the reason(s) for establishing the terms, and the right to appeal and request a hearing with respect to either (See Part 10-05-2 of this Title), as well as all other information required in this section. The enrollment referral transmitted to the RIte Share Unit shall also indicate which terms apply and shall be sent at the time the redetermination is made.

3.16 Renewal of RIWorks Participants

A. At the time eligibility renewals are completed, EOHHS is responsible for assessing whether RIWorks participants are subject to enroll in a RIte Share-approved plan as a condition of Medicaid eligibility.

1. Employed under six (6) months - Only those RIWorks participants, age nineteen (19) or older, who have access to ESI and have been steadily employed for a period of six (6) consecutive months or more, shall be subject to enrollment in RIte Share. All other RIWorks participants continue enrollment in the RIte Care plan which provided coverage until the next scheduled redetermination of eligibility.

2. Employed six (6) months or over - If the RIWorks participant has been employed for over six (6) months, the notice of renewal sent by EOHHS must state that enrollment in the RIte Care plan that provided coverage during the previous period of eligibility is continued, pending review of the ESI plan by the RIte Share Unit. If enrollment in an approved ESI plan is a condition of retaining continuing eligibility, Medicaid beneficiaries shall receive notice from the RIte Share Unit at least fourteen (14) days prior to enrollment in an ESI plan.

3.17 RIte Share Premium Assistance Payment

A. It is the responsibility of EOHHS to establish the appropriate mechanism for transferring payment for the RIte Share-approved ESI plan premiums.

1. The payment options include:

a. Enrollment costs are paid directly by the employer without any wage withholding from the policy holder. The RIte Share Unit or its agent either mails a check or electronically transfers payment to the employer's bank or account, on a monthly basis, to cover the enrollment costs for any individuals/families on the ESI as a result of RIte Share enrollment. These are called “participating” employers.

b. Enrollment costs are paid by the employer after wage withholding from the policy holder. The RIte Share Unit or its agent mails a check or electronically transfers payment to the policy holder, on a monthly basis, to cover the enrollment costs for any individuals/families on ESI as a result of RIte Share enrollment.

c. Enrollment costs (both the employer's premium share and the employee's premium share or employee's premium share only) are paid directly to the insurance carrier on a monthly basis by the RIte Share Unit or its agent. (If both the employer and employee enrollment costs are paid, EOHHS then bills the employer for the employee's enrollment costs).

2. Notice of payment method -The notification of RIte Share participation sent to the beneficiaries shall clearly specify the method for paying enrollment costs.

3.18 Role of RIte Share Unit

A. The RIte Share Unit is responsible for overseeing the operations of the program as follows:

1. Eliciting information from employers about the health plans they offer to workers on an ongoing basis;

2. Evaluating health plans for RIte Share approval;

3. Maintaining a database of RIte Share-approved ESI plans; and

4. Contacting employers to make RIte Share enrollment decisions.

B. Upon receipt of beneficiary referral information, the RIte Share Unit verifies employment and access to a RIte Share-approved ESI plan. Based on this review, the RIte Share Unit determines:

1. Whether the Medicaid beneficiary is approved for RIte Share; and

2. The date that individual or family must enroll in the ESI in order to maintain Medicaid eligibility.

C. The specific procedures for making such determinations vary depending on the enrollment status of the Medicaid beneficiary and the employer’s customary enrollment process.

3.19 ESI Enrollment Verification

A. Verification of enrollment in a RIte Share-approved ESI plan is required.

1. Participating employer - For Medicaid beneficiaries working for a RIte Share “participating” employer, the employer is required to submit verification to the RIte Share Unit that initial enrollment in the ESI has been made in the manner prescribed by EOHHS.

2. Approved plan - For individuals working for a RIte Share-approved employer, the individual must provide verification of enrollment by completing the appropriate form, which requires the signature of a representative of the employer

or submitting a copy of the official ESI enrollment receipt. Once this verification has been received, EOHHS will initiate premium payment.

3.20 Failure to Enroll

A. Failure to enroll in the ESI plan is grounds for termination of Medicaid eligibility for the non-pregnant parent(s) or caretaker over the age of nineteen (19) in the household.

1. Discontinuation - EOHHS sends a "Notice of Discontinuation", stating that Medicaid eligibility has been terminated for adults in the household due to the failure to enroll in the RIte Share-approved plan. Anyone in the household subject to the notice may reapply (for inactive cases) or request reinstatement (for active Medicaid cases) if they choose to comply with RIte Share, if an exemption from participation is granted, or if the individual no longer has access to the ESI. Please refer to § 3.5 of this Part.

2. Disqualification - Procedures for handling cases in which the policy holder is not eligible for Medicaid are the same as for an eligible policy holder, with one exception: The Medicaid agency sends a "Notice of Disqualification" to the policy holder indicating that ESI costs will not be paid by EOHHS. Please refer to § 3.5 of this Part.

B. Both the "Notice of Discontinuation" and the "Notice of Disqualification" shall include a statement indicating that any affected Medicaid-eligible individuals in the household have the right to appeal and to request a hearing to contest the change in eligibility and the enrollment decision.

3.21 Disenrollment from RIte Share-Approved Plan

A. RIte Share beneficiaries who are voluntarily or involuntarily disenrolled from an approved ESI plan must report the change in enrollment status to EOHHS in no more than ten (10) days from the date the disenrollment action occurs. The type of disenrollment determines EOHHS's response as follows:

1. Voluntary disenrollment - Medicaid-eligible RIte Share beneficiaries age nineteen (19) or older who voluntarily disenroll from an approved ESI will be terminated for coverage based on the failure to meet the non-financial cooperation requirements set forth in this Part. Voluntary disenrollment includes, but is not limited to, instances in which a RIte Share beneficiary:

a. Requests that the employer drop coverage or cease enrollment for the entire family or a Medicaid-eligible individual in the family;

b. Fails to meet the requirements established by the employer to maintain enrollment in the approved plan such as, submit required documentation or forms.

c. Engages in unlawful or fraudulent acts, such as submitting false claims that violate the terms for continuing enrollment in the ESI plan. Please refer to § 3.5 of this Part.

2. Involuntary disenrollment - Involuntary disenrollment includes the loss of access to ESI as a result of change in employment, termination of coverage by the employer for an entire class of workers, death, separation, divorce, disability of the policy holder, or any other factors that could be reasonably construed as involuntary disenrollment as defined in this Part.

3. RIte Share Unit responsibilities - Upon receiving a report from the employer, the ESI plan insurance provider, or Medicaid beneficiary indicating that disenrollment has occurred, the RIte Share Unit verifies the accuracy of the report and assesses whether it is voluntary or involuntary in nature.

a. Voluntary Disenrollment - Notice of Discontinuation. Once the report has been verified and it is determined to be voluntary disenrollment, EOHHS sends a "Notice of Discontinuance" noting termination of the Medicaid eligibility of the policy holder, parent(s) or caretaker relative in the applicant's household until the individual demonstrates compliance with enrollment procedures established by EOHHS. The "Notice of Discontinuance" must also include any remedies for shortening the period of ineligibility as well as the right to request a hearing and appeal the decision:

(1) Medicaid-ineligible individuals are provided with a notice from EOHHS stating they are disqualified from RIte Share.

(2) All Medicaid-eligible pregnant women and children must be automatically enrolled in a RIte Care plan.

(3) This period of Medicaid ineligibility may be shortened and Medicaid eligibility established if such individual becomes exempt from RIte Share enrollment or no longer has access to ESI for reasons such as a change in employment. (See § 3.21 of this Part).

b. Involuntary disenrollment - There is no adverse action taken against Medicaid beneficiaries required to participate in RIte Share if disenrollment from an approved ESI plan is involuntary.

3.22 Cooperation Requirements

A. All Medicaid applicants and beneficiaries must cooperate with the non-financial requirements for eligibility as follows:

1. Information - All individuals and families are required to provide information about other health coverage (TPL) and/or access to ESI when applying for initial

or continuing eligibility. The required information relating specifically to access to ESI includes, but is not limited to:

a. The names of any family members in the household currently covered by, or with access to, ESI;

b. The name of the policy holder and the employer offering the ESI; and

c. Verification of monthly enrollment costs via a paycheck stub if the policy holder is currently enrolled or, if available, enrollment information provided by the employer indicating the policy holder's monthly premium for the appropriate family composition.

2. RIte Share participation - Medicaid beneficiaries required to enroll in the ESI must cooperate as follows:

a. Enroll in the ESI in the manner, and within the timelines, established by EOHHS. Failure to do so will result in the termination of Medicaid for any eligible parents/caretaker age nineteen (19) and older in the family. The eligibility of any other Medicaid beneficiaries in a family must not be terminated as the result of the refusal of an otherwise ineligible policy holder to enroll in the ESI. See § 3.20 of this Part.

b. Submit verification of enrollment in accordance with § 3.19 of this Part when the employer does not participate in RIte Share.

c. Provide reports to EOHHS indicating any changes in enrollment status of Medicaid-eligible family members, enrollment costs, household composition, employment, income, residence, and access to ESI within ten (10) days from the date the change occurs.

d. Pay buy-in amounts - Medicaid beneficiaries subject to the buy-in requirements must cooperate in making monthly buy-in payments in accordance with § 3.7 of this Part to remain eligible for Medicaid. Failure to make a required premium payment, without good cause, as specified in § 3.23 of this Part, results in disenrollment from the RIte Share Premium Assistance Program and loss of Medicaid eligibility.

3.23 Good Cause

A. EOHHS is responsible for determining whether good cause exists for an exception to the non-financial cooperation requirements for Medicaid eligibility contained in Section MCAR 1305, “Eligibility Requirements” and, more specifically, for participation in RIte Share, except as noted below:

1. Extraordinary circumstances - EOHHS must exempt a Medicaid beneficiary from RIte Share participation only when there are extraordinary circumstances

which preclude the individual from receiving medically necessary care through the RIte Share-approved plan. For purposes of this exemption, "extraordinary circumstances" may include but not be limited to:

a. The existence of an unusual and life-threatening medical condition which requires medical treatment that cannot be provided or arranged by the RIte Share plan whether it is provided through the custodial or non-custodial parent;

b. The existence of a chronic, severe medical condition for which the Medicaid beneficiary has a long-standing treatment relationship for that condition with a provider who does not participate in the RIte Share plan; or

c. Enrollment in the health plan of the non-custodial parent could result in reasonably anticipated physical and/or emotional harm to the child, custodial parent, or other relative with whom the child is living. Claims of physical and/or emotional harm must be determined by EOHHS to be of a genuine and serious nature. The emotional harm to the custodial parent or other relative with whom the child lives must be of such a serious nature that the capacity to care for the child adequately would be reduced.

2. Corroborative evidence - Such evidence supporting a determination of good cause must be supplied to EOHHS. Corroborative evidence may include: court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the non-custodial parent might inflict physical and or emotional harm on the child, custodial parent, or other relative with whom the child lives.

3. Other programs - If good cause has been granted for any other benefit program administered by EOHHS or DHS, the good cause exemption will be honored by the RIte Share Program.

4. Nature of request - Enrollment exemptions requested due to extraordinary circumstances must be in writing, with appropriate documentation (letter from physician, medical records, restraining orders, or others as indicated), and signed by the Medicaid beneficiary, parent/caretaker or person designated to make the request on their behalf.

5. Basis of the determination - EOHHS makes RIte Share participation exemption determinations on a case by case basis after considering all required documentation and any other relevant information pertaining to the request. An exemption may be granted for any length of time during the period in which the extraordinary circumstances exist. When an exemption is granted, Medicaid beneficiaries are enrolled in the appropriate Medicaid managed care plan in accordance with Part 2 of this Subchapter.

6. Limits - An individual's preference to continue a treatment relationship with a doctor or other health care provider who does not participate in the RIte Share plan does not in and of itself constitute an "extraordinary circumstance."

3.24 Notice and Appeal Rights

Medicaid applicants and recipients shall receive timely notification of eligibility and enrollment determinations and the right to appeal. EOHHS shall also provide timely notification, including appeal rights, of any adverse decisions that reduce or terminate benefits. See Part 10-05-2 of this Title for full statement of these rights.

3.25 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 1-855-609-3304 and TTY 1-888-657-3173.

3. For assistance finding a place to apply or for assistance completing the application, please call: 1-401-462-0311, 1-855-609-3304 or 1-855-840-HSRI (4774).

3.26 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.

Chapter 30 - Medicaid for Children, Families, and Affordable Care Act (ACA) Adults

Subchapter 10 - Premium Assistance

Rhode Island Affordable Health Care Coverage Assistance Program (210-RICR-30-10-1)

1.1 Overview and legal authority

R.I. Gen. Laws § 40-8.12-3 mandated the Executive Office of Health and Human Services (EOHHS) to establish a fund to ensure insurance coverage through HealthSource RI is affordable for parents and caretakers of Medicaid-eligible children in households with incomes below 175% of the Federal Poverty Level (FPL). The fund is available to assist caretakers who are not otherwise eligible for Medicaid through the RI Affordable Health Care Coverage Assistance Program (AHCCA).

1.2 Scope and Purpose

A. Caretakers of Medicaid-eligible children in households with incomes below 175% FPL who are not Medicaid eligible themselves can apply for financial assistance for paying for health insurance coverage accessed through HealthSource RI.

B. The purpose of this rule is to set forth the provisions governing this financial assistance. The rule describes the scope of the Affordable Health Care Coverage Assistance (AHCCA) Program, the basis for determining eligibility, and the respective responsibilities of the State and the individuals seeking assistance through the Program.

1.3 Definitions

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

1. “Affordable Care Act” or “ACA” means the federal Patient Protection and Affordable Care Act of 2010. The law is also sometimes referred to as “Obamacare” and federal health reform.

2. “APTC/CSR eligibility” means the application of the IRS-based measure of income known as “Modified Adjusted Gross Income” (MAGI) for determining eligibility for affordable health care through health insurance exchanges/marketplaces established under the ACA. Also, “APTC” means advanced premium tax credits and “CSR” means cost-sharing reductions.

3. “Caretaker” means any adult over age nineteen (19) living with a Medicaid-eligible dependent child who has assumed primary responsibility for that child as defined in MCAR section 1305.13, “Eligibility Requirements.” This term includes relatives and non-relatives.

4. “HealthSource RI” means the state-based health insurance marketplace (also referred to as a “benefit exchange”) established in conjunction with implementation of the federal Affordable Care Act of 2010.

5. “Qualified Health Plan” means a health plan certified by HealthSource RI that provides essential benefits and meets all other related ACA requirements to be offered through the State’s health benefits exchange.

6. “Silver Plan” means a Qualified Health Plan offered through HealthSource RI that covers approximately 70% of an enrollee’s medical costs. There are federal subsidies for certain Silver Plan enrollees to help cover co-payments and other out-of-pocket expenses.

1.4 Eligibility Requirements

A. Caretakers must meet certain requirements related to income, health coverage, and relationship to be eligible to participate in the AHCCA Program. Coverage through HealthSource RI is also a condition of eligibility.

1. Eligibility - The requirements are as follows:

a. Income. Household income at or under 175% of the FPL.

b. Health coverage. Caretakers must not be otherwise eligible for Medicaid.

c. Relationship. Caretakers need to have primary responsibility for a Medicaid-eligible child who is under the age of nineteen (19).

d. Must pay their monthly Silver Plan premium on-time.

2. Plan enrollment - AHCCA financial assistance will be available only if the applicant has enrolled in a Silver Plan through HealthSource RI.

1.5 Application Process

A. Caretakers must submit an application for AHCCA through EOHHS.

1. Application forms will be available at the HealthSource RI Contact Center located at: 401 Wampanoag Trail, Riverside, RI 02915 or at EOHHS, Virks Building, 3 West Road, Cranston, RI 02920 or at www.eohhs.ri.gov or www.HealthSourceRI.com. Applicants must also provide basic demographic information and information regarding enrollment in a Qualified Health Plan through HealthSource RI.

2. State’s Responsibilities - EOHHS must review and determine eligibility for financial assistance within sixty (60) days. If additional information is needed by

EOHHS, a new review period will begin once the additional information has been received.

1.6 Eligibility Approval - Premium Amount

A. If a caretaker is approved, EOHHS calculates the AHCCA subsidy amount in accordance with the following chart:

Rhode Island Affordable Health Care Coverage Assistance Program Assistance		
Total Family Size	138 % FPL to 150% FPL	151% FPL to 175 % FPL
2	$39	$28
3	$49	$43
4	$59	$58
5	$69	$73
6	$79	$88

1.7 Notice

EOHHS, or its agent, must send a notice to the caretaker with an eligibility determination for AHCCA. All notices must include a statement of the rights of the caretaker applying.

1.8 Payment of Subsidies

The payment option for the AHCCA subsidy includes the following: The caretaker pays the premium due to the insurer to HealthSource RI. EOHHS or its agent mails a check to the caretaker monthly.

1.9 Duration and Continuing Eligibility

A. Period of eligibility - Eligibility for the AHCCA subsidy is on a month-to-month basis. The subsidy may be curtailed sooner if there is a change in any eligibility factor that affects household or enrollment in the Qualified Health Plan selected by the caretaker. Continuation of the subsidy must be reconsidered if such a change occurs, if eligibility under § 1.4 of this Part still applies, AHCCA financial assistance continues.

B. Notice - EOHHS must provide notice to the eligible caretaker sixty (60) days prior to termination. The notice must include guidance on how to apply for continued financial assistance as well as the right to appeal EOHHS actions as indicated in § 1.10 of this Part.

1.10 Termination or Denial of Participation

Eligibility for the AHCCA must be denied or terminated, as appropriate, upon determining that an applicant has provided false information on an application for assistance or has not provided timely notification of changes that would affect the eligibility factors set forth in § 1.4 of this Part.

1.11 Hearing and the Right to Appeal

A. EOHHS must provide applicants and recipients of AHCCA subsidies with notice of the right to appeal and request a hearing with regard to the following agency actions:

1. A determination that an applicant disapproved for AHCCA participation and the basis for the decision of ineligibility;

2. The amount of assistance determined;

3. Termination of eligibility to participate in the AHCCA. (See regulations contained in Part 10-05-2 of this Title).

1.12 For Further Information or to Obtain Assistance

A. See the following websites:

1. www.eohhs.ri.gov

2. www.HealthSourceRI.com

B. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1-855-840-HSRI (4774) or the Premium Assistance Program at 401-462-0311.

1.13 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.

Chapter 30 - Medicaid for Children, Families, and Affordable Care Act (ACA) Adults

Subchapter 15 - Early Intervention

Early Intervention Program (210-RICR-30-15-1)

1.1 Purpose

A. The purpose of the Rhode Island Early Intervention (EI) Program is to provide a comprehensive, and coordinated, system of home and community based services and supports for families of infants and toddlers with developmental disabilities or delays.

B. The purpose of Early Intervention is to:

1. Enhance the capacity of families to meet the special needs of their infant or toddler.

2. Enhance the developmental functioning of infants and toddlers with special needs.

C. The intent of Rhode Island's Early Intervention system is to establish and support a service delivery model that supports the development of infants and toddlers and utilizes evidence-based practices known to promote learning in young children. This service delivery model identifies the parent/adult caregiver as the primary consumer of Early Intervention services because he/she is the primary agent(s) of change for the child's well-being and development.

1.2 Statewide Equity

Children and families must have equal access to comprehensive Early Intervention services, as defined in these regulations, irrespective of geographic location. The provision of Early Intervention must be fully compliant with all provisions of the regulations. Early Intervention must be made available to all children referred irrespective of gender, race, ethnicity, religious beliefs, cultural orientation, citizenship, economic status, and educational or medical diagnosis.

1.3 Definitions

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

1. "Act" means R.I. Gen. Laws Chapter 23-13, as amended.

2. "Children" means infants and toddlers from birth through age two (2), who need early intervention services.

3. "Council" means the state Interagency Coordinating Council.

4. "Days" means calendar days.

5. "Department" means the Rhode Island Executive Office of Health and Human Services.

6. "Developmental delay" means significant delay in the developmental areas of cognition, communication development, and physical development, including vision and hearing, social or emotional development, and/or adaptive behavior.

7. "Early Intervention System" means the total effort in the state that is directed at identifying and meeting the needs of eligible children and families.

8. "Early Intervention provider" means an entity (whether public, private or nonprofit) or an individual that provides early intervention services.

9. "Early Intervention services" (here and after referred to as "EIS") means services that are designed to meet the unique developmental needs of the eligible child and the needs of the family related to enhancing the child's development.

10. "Evaluation" means the procedures used by qualified personnel to determine the child's eligibility.

11. "Infants and toddlers with disabilities" means individuals from birth through age two (2) who:

> a. Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay;
>
> b. Are experiencing developmental delays as measured by a norm-referenced standardized tool that identifies a delay that is 2 standard deviations below the mean in at least one area of development, or 1.5 standard deviations below the mean in two or more areas of development. Areas of development include: cognitive development, physical development (including vision and hearing), communication development, social or emotional development, adaptive development; or

c. Through the use of informed clinical opinion, the multidisciplinary team identifies a significant delay not captured by test scores, significant, atypical behaviors, or significant circumstance.

d. In order to be eligible under informed clinical opinion, there must be an impact on child/family functioning to the degree that without intervention developmental delay would result.

12. “Lead agency” means the Rhode Island Executive Office of Health and Human Services (EOHHS).

13. Multidisciplinary" means involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment and development of an IFSP (Individualized Family Service Plan).

14. "Parent" means:

a. General:

(1) A biological or adoptive parent of a child;

(2) A guardian generally authorized to act as the child’s parent, or authorized to make early intervention, educational, health or developmental decisions for the child (but not if the child is ward of the state);

(3) A person acting in the place of a biological or adoptive parent (such as a grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare);

(4) A surrogate parent who has been assigned in accordance with existing state law and procedures outlined in the Rhode Island Early Intervention Certification Standards. The term does not include the state if the child is a ward of the state.

(5) Foster parent. If the biological parents' authority to make the decisions required of parent under the Act has been extinguished under state law.

b. The term does not include the state if the child is a ward of the state.

15. “Part C” means Part C of the Individuals with Disabilities Education Improvement ACT of 2004 that addresses infants and toddlers, birth through two (2) years of age with developmental delays or disabilities or physical or mental conditions with a high probability of resulting in significant delay in development in accordance with 34 C.F.R. 303.

16. Person" means any individual, trust or estate, partnership, corporation (including associations, joint stock companies), limited liability companies, state or political subdivision or instrumentality of a state.

17. "Qualified personnel" means personnel who provide Early Intervention services and who have met state approved or recognized certification, licensing, registration, or other comparable requirements that apply to the area in which the person is providing EIS as outlined in the Rhode Island Early Intervention Certification Standards.

18. “Rhode Island EI Certification Standards” means the policies and procedures defined by the EOHHS to ensure compliance with Part C of IDEA (Individuals with Disabilities Education Act), state regulations and to ensure the provision of quality services and supports to eligible families of infants and toddlers with developmental disabilities and delays in Rhode Island.

19. "Secretary" means the Secretary of the Rhode Island Executive Office of Health and Human Services.

1.4 Lead Agency

The EOHHS is the lead agency responsible for Early Intervention services for infants, toddlers, and their families consistent with final Part C of IDEA regulations effective September 6, 2011 and R.I. Gen. Laws § 23-13-22, as amended.

1.5 Interagency Coordinating Council (ICC)

1.5.1 COMPOSITION OF ICC

A. The lead agency shall establish a State Interagency Council and shall provide assistance and resources to the council. The composition of the Council is specifically determined by criteria set forth in Part C of IDEA and in accordance with bylaws. Members of the Council are appointed by the Governor. The Governor shall ensure that the membership of the Council reasonably represents the population of the state.

B. The Governor shall designate a member of the Council to serve as the chairperson of the Council. Any member of the Council who is a representative of the Department may not serve as the chairperson.

C. Appointments to the Council are for a two-year term. Composition of the Council shall include, but not be limited to:

1. At least twenty percent (20%) of parents of infants or toddlers including minority parents who have been enrolled in the Early Intervention Program within the past three (3) years [minimum 20%];

2. At least twenty percent (20%) of providers of early intervention services [minimum 20%];

3. One (1) representative from the legislature;

4. One (1) college or university member involved in personnel preparation;

5. One (1) pediatrician;

6. One (1) representative from each of the state human service agencies involved in the provision of or payment for EIS to infants and toddlers with disabilities and their families (Children, Youth and Families; Education; Health; Human Services; Behavioral Healthcare, Developmental Disabilities, and Hospitals) having sufficient authority to do policy planning or implementation on behalf of the agency;

7. One (1) representative from the advocacy community for children with special needs and their families;

8. At least one (1) representative from the Department of Business Regulation, the agency responsible for state governance of health insurance;

9. At least one (1) representative from the Rhode Island Department of Education, Director of Special Education, responsible for preschool services to children with disabilities. This may or may not be the same representative of the Department of Education as required in subsection (f);

10. At least one (1) member from Head Start / Early Head Start;

11. At least one (1) member from a state agency responsible for child care. This may or may not be the same representative of the Department of Children, Youth, and Families as required in subsection (f);

12. At least one (1) member from the State Medicaid Agency;

13. At least (1) member from the Office of the Coordinator of Education for Homeless Children and Youth;

14. At least one (1) member from the state child welfare agency responsible for foster care. This may or may not be the same representative of the Department of Children, Youth, and Families as required in subsection (f);

15. At least one (1) member from the state agency responsible for children's mental health.

D. The Council may include other members selected by the Governor.

E. Council shall assume the following responsibilities consistent with the provisions of Part C of IDEA:

F. The Council will meet at least quarterly as stated in the by-laws;

G. The Council shall announce meetings in sufficient time as to ensure attendance;

H. Council meetings shall be open and accessible to the general public;

I. Interpreters for the deaf and other services needed to support participation of all interested parties will be provided as necessary;

J. No member of ICC may vote on any matter providing direct financial benefit to self or give appearance of conflict, and must conform to the provisions of R.I. Gen. Laws Chapter 36-14, as amended, entitled "Code of Ethics";

K. Advise and assist the EOHHS in the development and implementation of the policies that constitute the statewide system;

L. Assist the EOHHS in achieving the full participation, coordination, and cooperation of all appropriate public agencies in the state;

M. Assist EOHHS in implementation of the statewide system by establishing a process that includes seeking information from service providers, service coordinators, parents, and others about any federal or state or local policies that impede timely service delivery, and taking steps to ensure that policy problems are identified and resolved;

N. Assist EOHHS in resolution of disputes to the extent deemed appropriate;

O. Advise and assist EOHHS and state education agency (SEA) in obtaining appropriate services for children ages birth-5 inclusive;

P. Advise and assist SEA regarding transition of toddlers with disabilities to services under Part B to preschool and other appropriate services;

Q. Advise or assist EOHHS in the preparation of applications and amendments for applications;

R. Assist EOHHS in the identification of fiscal sources of support for early intervention programs;

S. Assist in the assignment of financial responsibility to the appropriate agency;

T. Assist in the promotion of interagency agreements;

U. Submit an annual report to the Governor and to the Secretary of Education on the status of early intervention programs within the state.

1.6 Rhode Island Early Intervention Certification Standards

A. The EOHHS shall establish and implement Rhode Island Early Intervention Certification Standards.

B. The certification process provides the basis for EOHHS to determine that providers are eligible to participate in and receive payment for the provision of Early Intervention services. Providers must be in conformity with EOHHS' Rhode Island Certification Standards.

C. The Rhode Island Early Intervention Certification Standards establish the policies and procedures required of an Early Intervention program in Rhode Island.

D. Full compliance with the Rhode Island Early Intervention Certification Standards is required of all certified Early Intervention programs.

E. The EOHHS is responsible for the oversight and monitoring of compliance with these standards.

F. Changes to the standards may be made by the EOHHS in order to comply with federal or State regulations and/or to ensure funding, with reasonable notice to providers. Substantial changes to the standards will require certified providers to submit revised or new program policies and an agreement to comply with any changes.

G. The EOHHS will hold public hearings on any new or revised policy or procedure outlined in the Rhode Island Early Intervention Certification Standards and provide notice of the hearing held in accordance with 34 C.F.R. § 303.208(b)(1) at least 30 days before the hearing is conducted in order to enable public participation. The EOHHS will also provide opportunities for the general public, including individuals with disabilities, parents of infants and toddlers with disabilities, Early Intervention providers, and members of the Interagency Coordinating Council, to comment for at least 30 days on the new or revised policy or procedure needed to comply with Part C of IDEA.

H. No person shall provide EI services as an EI service provider without first becoming certified by the EOHHS.

I. In order to become certified as an EI service provider, an agency or organization shall submit notice of intent to apply for certification status to the EOHHS. Required documentation includes the submission of an Implementation Plan demonstrating compliance with the regulations herein, and the Rhode Island Early Intervention Certification Standards.

1. The Implementation Plan must include at a minimum:

    a. Initial Staffing and Supervision Plan;

    b. Initial Budget;

    c. Initial Organizational Plan including how Early Intervention fits into the agency structure;

    d. Evidence of an understanding of RI Early Intervention Principles and Practices;

    e. Evidence of understanding and the ability to comply with all state and federal requirements and RI Certification Standards.

J. Organizations must submit any change to program policies and procedures or organizational changes (impacting Early Intervention) to the EOHHS.

K. Certification shall be granted for a one-year period. Early Intervention Certification is valid and renewed annually, contingent upon continuing compliance with federal and state regulations and with the Rhode Island Early Intervention Certification Standards.

L. The EOHHS shall certify applicants as it deems appropriate and necessary in order to assure a viable statewide early intervention system that provides quality services to infants and toddlers with disabilities and developmental delay. Factors reviewed to ensure

that Rhode Island has the capacity to meet the need for Early Intervention include changes in population, performance indicators, or in the number of certified providers.

M. The EOHHS determines the structure of the Rhode Island Early Intervention system and shall make changes as needed.

N. The EOHHS will continually monitor compliance with Rhode Island Early Intervention Certification Standards. Technical assistance is available. The EOHHS may apply sanctions for non-compliance which may include but not be limited to:

1. Corrective action plans/Performance Improvement Plans;

2. Mandatory technical assistance;

3. Additional reporting requirements;

4. Suspension of new referrals;

5. Recoupment of funds;

6. Provisional certification status, suspension or termination of certification.

1.7 Monitoring

A. The EOHHS is responsible for the general administration, supervision and monitoring of certified Early Intervention programs and activities to carry out Part C of the Act.

B. The EOHHS shall establish and implement a system of general supervision that includes multiple methods to ensure implementation of Part C of the ACT, and compliance with Rhode Island Early Intervention Certification Standards, identify and correct noncompliance, facilitate improvement, and support practices that improve results and functional outcomes for children and their families.

C. Monitoring activities shall include annual determination about the performance of each certified Early Intervention provider.

1.8 Eligible Population

1.8.1 DEFINITION OF THE ELIGIBLE POPULATION

A. Children eligible for early intervention include:

1. Children with a single established condition. Criteria: The child has a diagnosed physical or mental condition that has a high probability of resulting in

developmental delays including, but not limited to, chromosomal abnormalities; genetic or congenital disorders; neurological, metabolic disorders; hearing impairments and visual impairments not corrected by medical intervention or prosthesis; congenital infections; severe attachment disorders and disorders secondary to exposure to toxic substances including fetal alcohol syndrome. Evidence of diagnosis must be in the child's record.

a. Children with established developmental delays. Criteria: The child exhibits a delay in one or more areas of development as measured by a norm referenced standardized tool that identifies a delay that is 2 standard deviations below the mean in one area of development, or 1.5 standard deviations below mean in two or more areas of development).

Or

b. Through the use of informed clinical opinion, the multidisciplinary team identifies a significant delay not captured by test scores, significant atypical behaviors or significant circumstances. In order to be eligible under informed clinical opinion, there must be an impact on child/family functioning to the degree that, without intervention, developmental delay would result.

1.9 State Interagency Coordination

It is the responsibility of the EOHHS to identify and coordinate all available resources for Early Intervention in the state including developing formal interagency agreements, assigning financial responsibility to the appropriate agencies and developing procedures for securing timely reimbursement of funds. Additional responsibilities include resolving intra- and interagency disputes and developing procedures to ensure that services are provided in a timely manner pending resolution of any disputes.

1.10 Central Directory of Services

A. The EOHHS shall oversee a central directory that is accessible to the general public (i.e., through the EOHHS's web site and other appropriate means) that is accurate and up to date and includes:

1. Information on research and demonstration projects in the state;

2. Professionals and other groups providing assistance to infants and toddlers with disabilities eligible for early intervention and their families;

3. Public and private early intervention services.

1.11 Comprehensive Child Find System

A. Child Find efforts shall be coordinated by the EOHHS with all state agencies and relevant community programs (e.g., Department of Education, Department of Human Services, Maternal and Child Health, Newborn Hearing Screening, Medicaid EPSDT, Department of Children, Youth and Families, Head Start, Early Head Start and First Connections Program). Screening (by Primary Care Providers, DOH Family Visiting Programs, and other community programs), direct referrals and public awareness, shall be implemented concurrently on a statewide basis to ensure that all infants and toddlers in the state who are eligible for services are identified, located, and evaluated.

B. Newborn screening shall occur for every child born in Rhode Island and includes screening at birth for risk factors related to developmental delay, or adverse developmental consequences. Follow-up screening shall occur at periodic intervals between birth and through age two (2). This initial screening may occur in the hospital and will continue via other health care providers in the community.

C. In-home screening, for all those identified as having risk factors, is a comprehensive process that is intended to identify children in need of additional services. After in-home screening is completed, and on-going risk factors have been identified, the child and family's needs will be addressed through a community based review process. Alternatively, children who are determined to have probable eligibility for EIS shall be referred to an EI service provider.

D. All early intervention service providers certified by the EOHHS shall implement a standard direct referral process as outlined in the Rhode Island Certification Standards which permits families and community-based agencies to refer infants and toddlers directly to programs for screening, evaluation and assessment to determine eligibility for EIS.

E. Referrals will be made by primary referral sources (i.e., hospitals, physicians, parents, child care centers, LEAs, public health facilities, other social service agencies and other health care providers) within seven (7) working days after the child is identified.

F. All children under the age of three who are involved in a substantiated case of child abuse or neglect or are identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure shall be referred to EI.

G. The EOHHS shall establish and implement a public awareness program that focuses on the early identification of infants and toddlers with disabilities and provides information to parents of infants and toddlers through primary referral sources.

Information is made available to families and the general public as well as primary referral sources.

1.12 Comprehensive System of Personnel Development

A. The EOHHS shall establish and implement a comprehensive system of personnel development including training paraprofessionals, and primary referral sources with respect to the basic components of early intervention and training personnel to coordinate transition services for infants and toddlers with disabilities. Functions of the Rhode Island Comprehensive System of Personnel Development shall include:

1. Recruitment and retention of qualified personnel;

2. Increased workforce capacity;

3. Professional development and technical assistance for the current workforce;

4. Implementation of evidence based practices;

5. Leadership development across the Rhode Island Early Intervention systems.

1.13 System of Payments

A. The Rhode Island Early Intervention system of payments includes a combination of state and federal funds and the use of public and private insurance. Early Intervention is a state-required benefit for all insurance plans issued in Rhode Island. RI General Laws §§ 27-18-64, 27-20-50, and 27-41-68 require private and public insurers based in Rhode Island and providing coverage for dependent children to cover the cost of Early Intervention services. Plans may not include deductibles, co-pays, or co-insurance. Rhode Island residents may have employer-sponsored health benefit plans or "self- insured" plans that are exempt from Rhode Island State law but these plans must follow federal law. These plans and other out-of-state plans may provide "essential benefits", including "rehabilitative and habilitative services and devices" depending on the plan design, which may cover early intervention services. Any Early Intervention service not covered by health insurance or health benefit plans exempt from Rhode Island State law including deductibles, co-pays or co-insurance is funded through the use of public and Part C funds.

B. The Rhode Island Early Intervention system of payments does not include any family fees, co-payments or deductibles. Therefore, there is no family payment system; no sliding or cost participation fees; no basis for determining fees; and no definitions regarding ability and inability to pay.

C. The Rhode Island Early Intervention system will ensure that parents are not charged any out-of-pocket costs for any Part C services. Fees will not be charged for the services that a child is otherwise entitled to receive at no cost to the parents including:

1. Implementation of the child find requirements;

2. Evaluation and assessment;

3. Service coordination;

4. Administrative and coordinative activities related to:

a. The development, review, and evaluation of IFSPs;

b. The implementation of procedural safeguards;

c. All Early Intervention services authorized on the IFSP, including any co-payments or deductibles related to these services.

D. The Rhode Island Early Intervention system does not charge any fees to parents, copayments or deductibles, therefore:

1. The inability of the parents to pay for services will not result in the delay or denial of services to the child or the child's family;

2. Families will not be charged any more than the actual cost of an Early Intervention service;

3. Parents with public insurance or benefits or private insurance will not be charged disproportionately more than those who do not; and

4. No fees will be charged to parents for failure to provide income information.

E. Parents are only responsible for the cost of their health insurance premiums.

F. No service a child is entitled to receive will be delayed or denied due to disputes between agencies regarding financial or other responsibilities.

G. All Part C services on the IFSP are available to the child and family whether or not consent to use insurance or Medicaid is required or provided.

H. Payor of Last Resort

1. Part C funds may be used for activities or expenses that are reasonable and necessary for implementing the Rhode Island Early Intervention system including direct Part C services for children and families and the cost of co-pays and deductibles. Part C funds will be used as the payor of last resort and cannot be used to satisfy a financial commitment for services that would otherwise have been paid for from another public or private source. However, if necessary to prevent a delay in the timely provision of appropriate Part C services to an infant/toddler or the family, funds may be used to pay the provider of services for services and functions authorized under Part C pending reimbursement from the insurance provider that has ultimate responsibility for the payment.

I. The Use of Private Insurance to Pay for Part C Services

1. Consent for the use of private insurance is not required because the Part C required specific protections are provided by Rhode Island state statutes governing insurance in Rhode Island. Parents who have insurance plans exempt from RI law are also afforded the required specific protections under Federal law.

a. Required Protection C.F.R. § 303.520(b)2(i)

(1) The use of private health insurance to pay for Part C services cannot count towards or result in a loss of benefits due to the annual or lifetime health insurance coverage caps for the infant or toddler with a disability, the parent or the child's family members who are covered under that health policy.

b. Required Protection C.F.R. § 303.520(b)2(ii)

(1) The use of private health insurance to pay for Part C services cannot negatively affect the availability of health insurance to the infant or toddler with a disability, the parent, or the child's family members who are covered under that health policy and health insurance may not be discontinued for these individuals due to the use of the health insurance to pay for Part C services.

c. Required Protection C.F.R. § 303.520(b)2(iii)

(1) The use of private health insurance to pay for Part C services cannot be the basis for increasing the health insurance premiums of the infant and toddler with a disability, the parent, or the child's family members covered under that health insurance policy.

J. Notification prior to the initial use of the parent's private insurance is required as well as consent to release personally identifiable information for billing purposes. Consent to release personally identifiable information can be revoked at any time without the risk of losing Early Intervention services.

K. The Use of Public Benefits or Public Insurance to Pay for Part C Services - Medicaid/RIte Care:

1. The use of public benefits or public insurance is allowed to pay for Part C services, however the following provisions must be followed:

a. Parents are not required to sign up or enroll in a public benefits or public insurance program as a condition for their child to receive Part C services.

b. Parental notification must be provided prior to using public benefits or public insurance of a child or parent if that child or parent is enrolled in a public benefits or public insurance program. Parental notification must include the following:

(1) A statement that in Rhode Island when using public insurance, parents have no out-of-pocket costs except for insurance premiums. Co-pays, co-insurance and deductibles are not charged to parents.

(2) Consent for disclosure of personally identifiable information to bill public insurance is not required because EOHHS administers both Part C and Medicaid.

(3) A statement that parents, who have both private insurance and public insurance, state Medicaid regulations require the use of private insurance as the primary insurance.

(4) In Rhode Island, consent is not required to bill private insurance because of specific protections provided in state statute and federal law. However, notification prior to the initial use of the parent's private insurance is required as well as consent to release personally identifiable information for billing purposes. (For parents with public insurance, consent to release personally identifiable information was provided upon enrollment in Medicaid). Consent to release personally identifiable information

can be revoked at any time without the risk of losing Early Intervention services.

L. If an infant or toddler or parent is enrolled in a public benefits or public insurance program, written parental consent is not required because the use of these benefits to pay for Part C services does not:

1. Decrease available lifetime coverage or any other insured benefit for the child or parent; or

2. Result in the child's parents paying for services that would otherwise be covered by public benefits or insurance; or

3. Result in any increase in premiums or cancellation of public benefits or insurance for the child or parent; or

4. Risk the loss of eligibility for the child or the child's parents for home and community-based waivers based on total health-related costs.

5. Prior to the initial use of private or public insurance, the EI provider must provide families with the following:

a. Procedural safeguards including the right to participate in mediation; request a due process hearing; or file a state complaint;

b. Written notice related to the use of private insurance and Medicaid.

1.14 Resolving Complaints

A. The Rhode Island EOHHS, as lead agency, is responsible to review, investigate and act on any complaints or allegations of noncompliance with Part C of IDEA or with Rhode Island Early Intervention Certification standards, policies, or procedures by a certified Early Intervention Provider. The complaint procedure is publicly available on the EOHHS website.

B. Any public agency, public employee, parent, private individual or organization may file a written complaint alleging that there has been an instance of noncompliance with IDEA Part C or with Rhode Island Certification Standards, policies, or procedures by any certified Early Intervention Provider.

C. The parent, organization, or individual filing the complaint must submit a signed written complaint to the Part C Coordinator and simultaneously forward a copy of the complaint to the EI provider serving the child.

D. The complaint must be completed, signed, dated and submitted to the Part C Coordinator. The Early Intervention Complaint form is given to parents at Intake and is available on line at: http://www.eohhs.ri.gov

E. The EI provider will assist the parent in filing a written complaint if requested.

F. The Early Intervention Complaint Form (or facsimile) shall be used and must include:

1. A statement that the EI provider has violated a requirement of Part C of the IDEA;

2. The facts on which the statement is based;

3. The signature and contact information for the individual filing the complaint; and

4. The name and address of the child;

5. The name of the EI provider serving the child;

6. A description of the nature of the problem of the child, including facts relating to the problem; and

7. A proposed resolution of the problem to the extent known and available to the party at the time the complaint is filed.

G. The violation must have allegedly occurred not more than one (1) year prior to the date that the complaint is received.

H. The lead agency will conduct an investigation of the complaint through interviews and a review of the early intervention record(s) or may determine that an independent on-site investigation is necessary. The complainant will be given the opportunity to submit additional information orally or in writing within the required timeline.

I. The EI provider will be given an opportunity to respond to the complaint; including at the discretion of the lead agency, a proposal to resolve the complaint.

J. A parent who has filed a complaint will be given an opportunity to voluntarily engage in mediation with the EI provider.

K. EI programs shall cooperate with the lead agency by providing full access to all records and personnel involved.

L. The lead agency will review all relevant information and determine whether there has been a violation of a requirement of the Rhode Island Early Intervention system and will issue a written decision within sixty (60) days. A time extension may be permitted only if exceptional circumstances exist with respect to the complaint or if the parent and the EI provider agree to extend the time to engage in mediation.

M. The written decision will address each allegation in the complaint and will contain the following:

1. Findings of facts and conclusions:

2. The reasons for the final decision;

3. The procedures to effectively implement the decision including corrective actions needed to achieve compliance, negotiations and technical assistance;

N. If the lead agency has found that the EI provider failed to provide appropriate services, the lead agency must address corrective actions required to correct the cause of the complaint. This includes corrective actions required of the system or of the EI program which impact the future provision of service for children with disabilities and their families, and compensatory services or monetary reimbursement as appropriate to the needs of the child and the child's family.

O. Final decisions are binding and enforceable. The lead agency may monitor the EI provider regarding implementation of corrective actions and if corrective actions are not implemented the lead agency may terminate the EI provider's certification agreement.

P. If an issue is raised in the written complaint, or there are multiple issues in which one or more are also part of a due process hearing request, the issue(s) must be set aside until the conclusion of the due process hearing. The remaining issues must be resolved using the written complaint time limits.

Q. If an issue is raised in the written complaint, which has already been decided in a due process hearing, the previous decision is binding and the complainant must be so informed.

R. A written complaint alleging a failure of the EI provider to implement a decision made pursuant to a "Request for Due Process Hearing" must be resolved by the lead agency.

S. If a parent is not satisfied with the final decision issued by the lead agency, a "Request for a Due Process Hearing" may be filed by the parent if the written complaint was about a proposal to initiate or change the identification, evaluation or early intervention services

of their child; or the refusal to initiate or change the child's identification, evaluation or early intervention services of their child.

1.15 Mediation

A. When filing a written complaint or a request for a due process hearing, families must be offered mediation as a formal method for resolving any dispute. Parents will be notified of mediation procedures in writing, initially and annually from the EI provider. Parents also receive written notice of all rights available to them whenever prior written notice is given.

B. The EOHHS will offer mediation to the parent as a first step in resolving a disagreement when the parent(s) file:

1. A written complaint;

2. A request for a due process hearing.

C. Mediation is voluntary on the part of all parties. The EOHHS identifies individual mediators to provide EI mediation services. EOHHS maintains a list of qualified and impartial mediators who are required to undergo training in effective mediation techniques and are knowledgeable in laws, regulations, policies and procedures related to the provision of EI services.

D. Mediation cannot be used to deny or delay the parent's right to a due process hearing or any other rights.

E. The parent may refuse or withdraw from the mediation process at any time.

F. The mediation process, including a written mediation agreement, must be completed to ensure enough time for completion of a due process hearing or complaint investigation by the lead agency, unless an extension of time has been granted by the EOHHS in the case of a written complaint or the hearing officer in the case of a due process hearing.

G. Each session in the mediation process must be scheduled in a timely manner and must be held in a location that is convenient to the parties (parent and EI service provider) to the dispute. The lead agency must bear the cost of the mediation process, including the costs of meetings or sessions described above.

H. If the parties resolve a dispute through the mediation process, the parties must execute a legally binding agreement that sets forth the resolution of the dispute and:

I. States that all discussions that occurred during the mediation process shall remain confidential and may not be used as evidence in any subsequent due process hearing or civil proceeding; and

J. Is signed by both the parent and a representative of the lead agency to bind the agency to what has been agreed upon;

K. A written, signed mediation agreement is enforceable in any state court of competent jurisdiction or in a district court of the United States.

1.16 Due Process Hearing

A. A due process hearing is a formal review of a complaint identified by the parent, all data related to the problem, and testimony from the parties concerned.

B. Parents may request a hearing with regard to:

1. A proposal to initiate or change the identification, evaluation or early intervention services of their child;

2. Refusal to initiate or change the child's identification, evaluation, or early intervention services of their child.

3. A request that information in their child's record be amended and the Early Intervention provider refuses to amend the record in accordance with the request (see Access to Records procedure).

C. A "Request for a Due Process Hearing" form must be completed, signed and dated by the parent or the parent's representative and submitted to the Part C Coordinator. This form is given to parents at intake and is also available online at: http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/EarlyInterventionProviders/EarlyInterventionProgram.aspx

D. The EI provider will assist the parent in filing a "Request for a Due Process" Hearing upon parent request.

E. When a hearing is requested by the parent, the lead agency will inform the parent of the right to mediation and of any free or low cost legal services available to the parent.

F. The hearing will be scheduled at a time and in a location that is convenient for the parents.

G. The due process hearing must be completed, and a written decision mailed to each of the parties within thirty (30) calendar days of the receipt of the request. Mediation, if attempted, must occur within the same thirty (30) days. A hearing officer may grant specific extensions of time beyond the period set, at the request of either party.

H. The hearing officer:

1. Shall not be an employee of the lead agency or program involved in the provision of early intervention services or care of the child, nor have a personal or professional interest that would conflict with his or her objectivity in implementing the process. A hearing officer cannot be an employee of an agency solely because the person is paid by the agency to implement hearing or mediation procedures under this part.

2. Shall have knowledge about the provision of early intervention and services available for infants and toddlers with disabilities and their families.

3. Shall listen to the presentation of viewpoints concerning the matter under review, examine all information relevant to the issues, and seek to reach a timely resolution of the matter.

I. Parents have the right to:

1. Be accompanied and advised by counsel and or individuals with special knowledge or training with respect to early intervention services for eligible children.

2. Present evidence and confront, cross-examine, and compel the attendance of witnesses.

3. Prohibit the introduction of any evidence at the hearing that has not been disclosed to them at least five (5) days before the proceeding.

4. Obtain a written or electronic verbatim transcription of the proceedings.

5. Obtain written findings of fact, conclusions of law, and decisions at no cost.

J. The hearing officer shall inform the parents or guardians and lead agency of their decision in writing within thirty (30) days of the request.

K. Any party disagreeing with the results of the hearing has the right to bring civil action in State or Federal court.

L. The lead agency shall ensure that the results of the hearing are implemented.

M. A child must continue to receive IFSP services consented to by the parent pending a hearing unless the parent and the EOHHS agree otherwise. If the hearing involves agreement on the initial IFSP, the child shall receive those services that are not in dispute.

1.17 Severability

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

Chapter 40 - Medicaid for Elders and Adults with Disabilities

Subchapter 00 - Integrated Coverage Groups

Overview of Medicaid Integrated Care Coverage (210-RICR-40-00-1)

1.1 Overview of this Chapter

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

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

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

3. Children and families in the IHCC category who are eligible on the basis of their participation in other programs - e.g., children in foster care or SSI-eligible -- are addressed in the Medicaid Code of Administrative Rules, Medicaid Coverage for Children and Families.

1.2 Authority

This chapter of rules entitled, "Medicaid Code of Administrative Rules: "Medicaid Integrated Health Care Coverage (IHCC)" is promulgated pursuant to the authority set forth in R.I. Gen. Laws Chapters 40-8 (Medical Assistance); Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); and the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15).

1.3 Scope and Purpose

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

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

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

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

1.4 Definitions

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

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

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

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

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

5. “Executive Office of Health and Human Services (EOHHS)” means the state agency that is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Title XIX Medicaid Program.

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

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

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

9. “Managed Care Arrangement (MCA)” means a system, often a managed care organization (MCO) that uses capitated financing to deliver high quality services

and promote healthy outcomes through a medical home. Such an arrangement also includes services and supports that optimize the health and independence of beneficiaries who are determined to need or be at risk for Medicaid funded LTSS. Section § 1.5 of this Part identifies the Medicaid managed care arrangements that serve IHCC elders, adults with disabilities and beneficiaries requiring LTSS; Medicaid Code of Administrative Rules Sections: RIte Care, Rhody Health Program, Enrollment, RIte Share Program, and Communities of Care pertain to managed Medicaid delivery systems for the MACC populations without regard to the basis for eligibility - MAGI, SSI, special requirements, etc.

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

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

12. “Primary Care Essential Benefits” means non-LTSS Medicaid health coverage, and includes an array of acute, subacute, and specialty essential benefits, as identified under the Medicaid State Plan, provided by licensed health professionals. These essential benefits include, but are not limited to: health promotion, disease prevention, health maintenance, counseling, patient education, various specialty services and diagnosis and treatment of acute and chronic medical and behavioral health illnesses and conditions in a variety of health care settings (e.g., office visits, inpatient, home care, day care, etc.).

13. “Primary Care Provider” means a health care practitioner who is licensed as:

a. a physician with a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine and is responsible for monitoring a beneficiary’s overall health; or

b. a nurse practitioner, clinical nurse specialist, or physician assistant and, to the extent licensure allows, is responsible for, or collaborates with a physician, monitoring a beneficiary’s overall health.

14. “Resource Standard” means the maximum amount of resources a person can have for Medicaid health coverage through an eligibility pathway or coverage

group subsequent to the application of all required exclusions. Also referred to as the "resource limit."

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

1.5 IHCC Groups Subject to the SSI Methodology

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

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

2. Medically Needy (MN) - Elders, persons with disabilities, children, parents and caretakers of Medicaid-eligible children, and pregnant women who do not qualify for eligibility on the basis of income but have high health expenses and must spend or contribute income and/or resources above the applicable income eligibility standards to obtain or retain Medicaid eligibility. Subchapter 5 Part 1 of this Chapter pertains to the MN eligibility pathway for Community Medicaid.

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

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

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

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

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

8. IHCC Medicaid LTSS -- Consists of new applicants seeking Medicaid-funded LTSS and current IHCC group beneficiaries who develop a continuous need for the level of care typically provided in an institution (hospital, nursing facility, intermediate care facility for person with intellectual disabilities). Beneficiaries eligible in the MACC groups (see Medicaid Code of Administrative Rules, Overview of the Affordable Care Coverage Groups) who require LTSS are not subject to the SSI methodology; LTSS eligibility based on the SSI methodology and more generally is located in Medicaid Code of Administrative Rules, Evaluation of Resources and Resource Transfers.

1.6 IHCC Special Coverage Groups

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

1. Low-income, uninsured women with breast or cervical cancer - Medicaid coverage group for uninsured women under age sixty-five (65) who are screened under the Centers for Disease Control and Prevention's (CDC) National Breast

and Cervical Cancer Early Detection Program and are found to need treatment for breast or cervical cancer or for precancerous conditions of the breast or cervix.

2. Refugee Medicaid Assistance (RMA) - Federally mandated coverage group for individuals and families operating under the auspices of the U.S. Department of Health and Human Services, Office of Refugee Resettlement. Refugees who qualify for this program receive eight (8) months of Medicaid health coverage or commercial coverage with financial help through HSRI, depending on income. Eligibility is evaluated first using the MAGI methodology set forth in Medicaid Code of Administrative Rules, Overview of the Affordable Care Coverage Groups, and the SSI standards for Community Medicaid in § 05-1.11.1 of this Chapter. Only persons in this group who are ineligible for Medicaid or commercial plan with financial help and have income at or below 200 percent of the FPL may qualify for MN coverage under this chapter.

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

1.7 The State's Integrated Eligibility System (IES)

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

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

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

3. Modified Passive Eligibility Renewal - The eligibility renewal process for IHCC group members has been reformed to ease the burden on beneficiaries. The State's new passive renewal process requires beneficiaries to review the eligibility information in their accounts, including updates through electronic data sources,

and notify the agency within a specified time period of any changes or discrepancies that may affect the continuation of coverage. The renewal process and variations across coverage groups are set forth in Part 2 of this Subchapter.

1.8 Medicaid Benefits

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

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

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

a. Community Medicaid. Beneficiaries eligible for health coverage receive the full scope of primary care essential benefits - including acute, subacute and rehabilitative services - as well as thirty (30) days of LTSS and, based on need, a limited set of LTSS preventive services. Subchapter 10 Part 1 of this Chapter identifies the scope of covered services available through the managed care and fee-for-service delivery options for IHCC group beneficiaries eligible for full Medicaid benefits. Note:

(1) The Medicaid benefits MPPP participants are eligible to receive may be limited to premium payment assistance only, depending on the basis of eligibility. See § 05-1.6.1 of this Chapter.

(2) For the scope of services covered under the Sherlock Plan, see Subchapter 15 Part 1 of this Chapter.

b. Medicaid LTSS. Medicaid LTSS includes health supports, personal care, and social services in an institutional or home and community-based

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

3. Integrated Care -- The State's Integrated Care Initiative (ICI) provides IHCC group members who have Medicare and other forms of third-party coverage who qualify for LTSS in accordance with the provisions set forth in the Medicaid Code of Administrative Rules, Overview of Medicaid and SSI-Related Coverage Groups, to obtain the coordinated services they need across the care continuum through a single plan. Subchapter 10 Part 1 of this Chapter covers these options and the process for plan selection and enrollment.

4. Retroactive Eligibility - Up to three (3) months of Medicaid retroactive coverage is available for certain IHCC group beneficiaries. To qualify, the State must determine that a person would have met the applicable eligibility criteria for his or her coverage group if the application was submitted during the retroactive period. The State provides reimbursement to providers only for Medicaid covered services, however. The provisions in Subchapter 5 Part 3 of this Chapter explain the process for obtaining retroactive coverage in greater detail.

1.9 Service Delivery Options

A. The service delivery options for IHCC group members are dictated in large part by type of Medicaid health coverage and eligibility pathway. Subchapter 10 Part 1 of this Chapter.

B.

Overview IHCC Group Service Delivery	
Eligibility Pathway	**Service Delivery Option**
SSI, EAD with no Medicare	Rhody Health Partners
SSI, EAD with Medicare	Rhody Health Options, PACE, Fee-for-Service (FFS) w/Community Health Team, or FFS-only

Overview IHCC Group Service Delivery	
Eligibility Pathway	**Service Delivery Option**
LTSS No Medicare	Same as above
LTSS with Medicare	Rhody Health Options, Medicare-Medicaid Plan II, PACE
Sherlock Plan - EAD and LTSS	FFS
Medically Needy - non-LTSS	FFS

Chapter 40 - Medicaid for Elders and Adults with Disabilities

Subchapter 00 - Integrated Coverage Groups

Application and Renewal Process for IHCC Groups (210-RICR-40-00-2)

2.1 Scope and Purpose

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

2.2 Access Points

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

1. Self-Service - Persons seeking initial or continuing eligibility have the option of accessing the eligibility system on-line using a self-service portal through links on the EOHHS (eohhs.ri.gov) and DHS (dhs.ri.gov) websites or directly through HSRI (HealthSourceRI.com). There are also kiosks located in DHS field offices that provide direct access to the self-service portal. The information applicants provide on-line is entered directly into the eligibility system and processed electronically in real-time. For these reasons, the Medicaid agency encourages all new applicants to select the self-service portal option and complete and submit the application electronically whenever feasible.

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

3. Applicants may submit paper applications in-person or by U.S. mail, e-mail transmissions, and facsimile transmissions to the address specified on the application. Paper applications are available on-line, through the U.S. mail upon written request, by telephone, or in person at any DHS field office. Information provided on the paper application is directly scanned or entered into the eligibility system through an agency portal by eligibility or LTSS specialists on the applicant's behalf.

2.3 Application and Renewal Assistance

A. The State provides application and renewal assistance through eligibility specialists in the DHS field offices and HSRI Contact Center and trained assisters, certified in accordance with 42 CFR 435.908. This assistance must be provided in a manner that is accessible to persons with disabilities and those who have limited English proficiency. Information on obtaining application/renewal assistance is available by calling 855-MYRIDHS (1-855-697-4347) as well as on-line through the DHS, HSRI and EOHHS websites using the links specified in this section. In addition, eligibility specialists and certified assisters are responsible for upholding the following rights of current and perspective Medicaid beneficiaries:

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

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

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

4. Timely Determinations - Eligibility determinations, including providing a notice of the agency's decision, must be made in accordance with the timelines indicated in § 2.4(A)(8) of this Part.

5. Appeals - The agency accepts appeals and holds hearings on actions related to eligibility decisions in accordance with Medicaid Code of Administrative Rules, Complaints and Appeals, or any successor regulation.

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

2.4 Completing and Submitting the Application

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

1. Account Creation - To initiate the application process, a person must create a login and establish an account in the eligibility system. This can be done through

the self-service portal by the person alone or with the help of an eligibility specialist or certified assister.

a. Identity proofing. The applicant must provide personally identifiable information for the purpose of creating an on-line account as a form of identify proofing during the process of applying for Medicaid. Verification of this information is automated. Documentation proving identity may be required if the automated verification process is unsuccessful. Acceptable forms of identity proof include a driver's license, school registration, voter registration card, etc. Documents may be submitted via mail, fax, on-line upload, or to a DHS Office.

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

2. Account Duration - An application account is open for a period of ninety (90) days. Applications may be started at any time. Once started, progress can be saved at any point and the application returned to at a later time. Incomplete applications not submitted within ninety (90) days are automatically deleted in the eligibility system.

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

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

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

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

(AA) Federal tax filing status

(BB) Social Security Numbers

(CC) Birth Dates

(DD) Passport or other immigration numbers

(EE) Federal tax returns

(FF) Information about any health coverage available to you or your family, including any information you have about the health insurance your current employer offers even if you are not covered by your employer's insurance plan, Medicare and other forms of coverage

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

(HH) 1099 forms, if you are self-employed.

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

(AA) Copies of checks or receipts for unearned or irregular income

(BB) Bank statements

(CC) Annuity/retirement fund statements for insurance companies

(DD) Copies of bonds

(EE) Stock ownership statements

(FF) Copies of life insurance policies

(GG) Statements from insurance companies or companies providing annuities

(HH) Copies of burial purchase agreements.

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

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

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

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

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

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

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

5. Application Completeness - An application must be complete before a determination of eligibility can be made. An application is considered complete when all information requested, including any ancillary required forms and authorizations, are date-marked as received by the State. As the timelines for making a determination of eligibility specified in subsection (8) below begin on the date the application is complete, applicants are informed and offered the opportunity to provide any additional documentation or explanations necessary to proceed to the determination of eligibility in a timely manner. Such information is provided to applicants immediately through an electronic notification from the

IES when applying on-line either through the consumer self-service portal or with the assistance of an agency representative. In cases in which an agency eligibility specialist or assister is entering information into an applicant's account or scanning a paper application, information about necessary documentation is generated immediately in the on-line account and must be made available as soon as feasible.

6. Voluntary Withdrawal - An applicant may request that an application for Medicaid health coverage be withdrawn at any time either through their secure on-line account or by submitting the request in writing via the U.S. mail or fax to the EOHHS or DHS agency representative. The Medicaid agency sends a notice to the applicant verifying the time and date of the voluntary withdrawal and indicating that the applicant may reapply at any time.

7. Self-Attestation of Application Information - All questions on the application must be answered in a truthful and accurate manner. Every applicant must attest to the truthfulness and accuracy by signing a paper application in ink or by providing an electronic signature on-line under penalty of perjury. The IES verifies the information electronically to the fullest extent feasible and must verify applicant attestations in accordance with the procedures set forth in the Medicaid Code of Administrative Rules, Application Process and Verification.

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

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

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

2.5 Beneficiary Responsibilities

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

1. Consent - At the time of the initial application or first renewal, Medicaid beneficiaries are required to provide the State with consent to retrieve and review any information not currently on record pertaining to the eligibility factors subject to change through electronic data matches conducted through the State's eligibility system. Once such consent is provided, the Medicaid agency may retrieve and review such information when conducting all subsequent annual renewals.

2. Duty to Report - Medicaid beneficiaries are required to report changes in eligibility factors to the Medicaid agency within ten (10) days from the date the change takes effect. Self- reports are permitted through the eligibility system consumer self-service portal as well as in person, via fax, or mail. Failure to report in a timely manner may result in the discontinuation of Medicaid eligibility.

3. Cooperation - Medicaid members must provide any documentation that otherwise cannot be obtained related to any eligibility factors subject to change when requested by the Medicaid agency. The information must be provided within the timeframe specified by the Medicaid agency in the notice to the Medicaid member stating the basis for making the agency's request.

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

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

6. Change of Service Delivery Options - Medicaid beneficiaries may change Medicaid health plans during the annual open enrollment period. Notice of the open enrollment period is provided to beneficiaries at least thirty (30) days prior to the date the period begins. Beneficiaries may also request to change service delivery options at any other time in accordance with the procedures set forth in Subchapter 10 Part 1 of this Chapter, or if MACC group eligible, Medicaid Code of Administrative Rules, RIte Care Program, Rhody Health Program, Enrollment, and RIte Share Program.

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

2.6 Application Review Process

2.6.1 Scope and Purpose

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

2.6.2 Conversion Process

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

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

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

2.6.3 General Rules

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

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

a. Retroactive coverage. Under the State's Section 1115 demonstration waiver, retroactive coverage is not available to MACC group beneficiaries, including those who qualify for LTSS. Retroactive coverage is an included benefit through many of the IHCC pathways in which the State determines eligibility for Community Medicaid and Medicaid LTSS, as indicated in Subchapter 5 Part 3 of this Chapter.

b. Other Health Coverage. Federal law precludes persons who are eligible for or enrolled in Medicare from obtaining coverage through the MACC

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

c. Former SSI Recipients. All former SSI recipients who lose cash benefits due to increases in income are evaluated first for the SSI protected status groups located in Subchapter 5 Part 1 of this Chapter. In instances in which eligibility in one of these groups is unavailable, the person will be evaluated for the MACC and/or IHCC Community Medicaid pathways, to the extent the other limiting factors in this subsection allow, and provided with a choice of coverage options as appropriate.

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

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

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

g. Medically Needy (MN) Eligibility. For all non-LTSS applicants, MN eligibility is considered the last option for obtaining Medicaid coverage, both because the burden on beneficiaries is the most significant and the opportunities for coordinating and managing care are so limited. There is not a MN option for MACC group adults, unless they are eligible through the pathway for parents/caretakers. Accordingly, for these adults IHCC

eligibility is the only avenue to MN coverage. For LTSS applicants, MN eligibility is also the last option; though the income eligibility limits are higher than through other eligibility pathways, beneficiary liability tends to be as well. In addition, access through this pathway limits access to SSP assistance (i.e., only available if income is at or below 300% of SSI) and the range of LTSS settings in some instances.

h. MPPP. Elders and adults with disabilities who are participating in the MPPP are only eligible for the MACC group for parents/caretakers. Otherwise, MPPP participants must access Medicaid financial help through the IHCC groups. In addition, participation in the MPPP has the potential to affect eligibility for Medicaid health coverage through the Community Medicaid MN pathway. As indicated in Subchapter 5 Part 2 of this Chapter, Medicare premiums are health expenses that count toward the amount a person must spenddown in order to obtain Medicaid coverage during the six month MN period. MPPP participants are not permitted to use these expenses toward a spenddown as they are paid by the State.

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

Selected Eligibility Cross Pathways By Population **(Excludes beneficiaries eligible on basis of other programs)**			
Population	**MACC Group - MAGI-Based** **(No Retroactive Coverage)**	**IHCC Group SSI methodology-based** **(Retroactive Coverage Possible)**	**Both MACC and IHCC Eligibility determined using both**
Children, no need for LTSS	Up to MACC income limit (261% of FPL +5% disregard)	MN only if income above MACC limit and have high health expenses	Not Applicable
Child requiring LTSS-health institution over 30 days	Not applicable	MN-LTSS	Not Applicable

Selected Eligibility Cross Pathways By Population **(Excludes beneficiaries eligible on basis of other programs)**			
Population	**MACC Group - MAGI-Based** **(No Retroactive Coverage)**	**IHCC Group SSI methodology-based** **(Retroactive Coverage Possible)**	**Both MACC and IHCC Eligibility determined using both**
Child requiring LTSS-HCBS	Up to MACC income limit for children	Family income above MACC limit - Katie Beckett eligibility based on child's income only MN-LTSS	Not Applicable
Pregnant Women	Up to MACC income limit (253% of FPL + 5% disregard)	EAD or MN if disabled, but only until next renewal or birth of baby, whichever comes first; MN if non-disabled and income above MACC limit and have high health expenses LTSS	Option for MACC and MPPP if have Medicare
Adults 19-64, no Medicare	Up to MACC income limit (133% FPL + 5% disregard), LTSS with no resource limit	EAD or MN if have a disability and are seeking retroactive coverage LTSS	Not Applicable
Adults with disabilities 19-64	If no Medicare, up to MACC limit for adults, including while awaiting a disability determination by the State or SSA	EAD, MPPP and/or MN Sherlock Plan if working LTSS	Option MACC group for parents/caretakers and MPPP
Elders	Only if a parent/caretaker	EAD, MPPP, MN LTSS	Option MACC group for parents/caretakers and MPPP

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

2.7 Renewal of Eligibility for IHCC Groups

2.7.1 Scope and Purpose

A. One of the principal requirements of Medicaid is that continuing eligibility must be re-evaluated at least once a year. For the IHCC groups, this annual review was called a "redetermination" and, accordingly, often required beneficiaries to reapply for coverage. Current federal regulations [42 CFR 435.916(b)] governing the IHCC groups now require that these annual reviews consider only those eligibility factors that are subject to change. Accordingly, the continuing eligibility of the IHCC group beneficiaries receiving Community and LTSS Medicaid is now conducted by requiring them to review their account information on key eligibility factors, as updated by internal and external data sources, and report any inaccuracies or changes in the manner described in this section.

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

2.7.2 Agency Responsibilities

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

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

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

3. Notice - Timely notice must be provided of:

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

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

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

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

a. Initial Automated IES Renewal. During the first automated IES renewal, IHCC beneficiaries are provided with a pre-populated form containing all information related to eligibility on record, typically in their IES accounts, that has been self-reported and/or obtained through

electronic data matches at application, post-eligibility verification, and change reports. Beneficiaries are required to review this form, make any necessary changes and required actions, and then attest to the accuracy and completeness of the information provided on any eligibility factor subject to change. In addition, the Medicaid beneficiary must provide consent to the EOHHS permitting automated data exchanges and/or retrieval of information on eligibility factors from outside sources for all future renewals.

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

2.7.3 Beneficiary Responsibilities

Medicaid beneficiaries must meet the requirements associated with making and completing an application as set forth in § 2.5 of this Part.

Chapter 40 - Medicaid for Elders and Adults with Disabilities

Subchapter 00 - Integrated Coverage Groups

Medicaid Integrated Health Care Coverage, SSI Financial Eligibility Determinations (210-RICR-40-00-3)

3.1 Overview of the SSI Methodology

3.1.1 Scope and Purpose

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

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

3.1.2 Organization of SSI Methodology Provisions in this Chapter

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

1. § 3.1 of this Part – Overview of Methodology
2. § 3.2 of this Part – Treatment of Income
3. § 3.5 of this Part – Treatment of Resources
4. § 05-1.11 of this Chapter — Community Medicaid

B. Except as otherwise noted, the provisions in this Part apply to the determination of countable income and resources for Medicaid LTSS applicants and beneficiaries in the Integrated Health Care Coverage groups. LTSS specific provisions related to the treatment of income and resources for IHCC members are set forth in Part 50-00-6 of this Title. The income of ACA expansion adults in the Medicaid Affordable Care Coverage (MACC) category is evaluated in accordance with Part 30-00-3 of this Title, except the

person seeking Medicaid LTSS is treated as family of one irrespective of whether he or she lives at home or a health institution or community-based service setting. All Medicaid LTSS applicant and beneficiaries, without regard for the method of determining financial eligibility, are subject to the transfer of asset provisions in §§ 50-00-6.6 through 6.12 of this Title.

3.1.3 Definitions

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

1. “Child” means someone who is not married, is not the head of a household, and is either under age 18 or is under age 22 and a student for the purposes of IHCC group eligibility only. See definition of a child for MACC group eligibility in the Medicaid Code of Administrative Rules, Coverage Groups.

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

3. “Federal benefit rate” or “FBR” means the amount of the monthly cash assistance authorized for the recipients of the SSI program. The FBR is the SSI income eligibility standard, as adjusted for the number of cash recipients, living arrangement and SSP levels as indicated in the table in § 3.1.7 of this Part.

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

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

6. “Medicaid health coverage” means the full scope of essential health care services and supports authorized under the State’s Medicaid State Plan and/or Section 1115 demonstration waiver provided through an authorized Medicaid delivery system. The term does not apply to partial dual eligible persons who, under the provisions of this Chapter, qualify only for financial assistance through the MPPP to help pay Medicare cost-sharing.

7. "Medically necessary service" means a medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of a health- related condition including any such services that are necessary to slow or prevent a decremental change in medical and/or mental health status.

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

9. “SSI income methodology” means the basis for determining Medicaid eligibility that uses the definitions and calculations for evaluating income and resources established by the U.S. Social Security Administration (SSA) for the SSI program.

3.1.4 Key Elements of the SSI Methodology

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

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

2. Characteristic Requirements – Due to the historical tie to the SSI program, some IHCC Community Medicaid group members must have certain characteristics related to age, blindness and disability, or clinical status to qualify for Medicaid health coverage. General characteristic requirements that drive eligibility for Community Medicaid are in Subchapter 05 of Part 1 of this Chapter.

3. LTSS Need and Level of Care – LTSS is a Medicaid State Plan benefit for both IHCC and MACC group beneficiaries who have the need for a level of care typically provided by a health care institution. Federal law defines “institution” narrowly in terms of three specific types of health facilities – nursing facilities (NF), intermediate care facilities for persons with developmental/intellectual disabilities (ICF-ID), and hospitals. To qualify for Medicaid-funded LTSS, MACC and IHCC group applicants and beneficiaries must meet the functional/clinical criteria related to level of need for care in one of these health institutions located in Part 50-00-5 of this Title.

4. General and Group Specific Eligibility Requirements - All persons seeking Medicaid benefits must also meet the general eligibility requirements related to residency, citizenship, third-party coverage and cooperation. The general eligibility requirements for IHCC Community Medicaid are specified in Subchapter 05 Part 1 of this Chapter as well as in the sections related to specific coverage group requirements. Documentation related to both financial and functional/clinical eligibility factors is specified in these same sections.

5. Clinical Reviews – Clinical reviews may consist of a determination of disability, an assessment of functional need and/or health status, or an evaluation whether an applicant or beneficiary requires the level of care provided in a health institution. The criteria and processes for making these determinations may vary considerably in accordance with the type of Medicaid health coverage a person is seeking and the scope of Medicaid coverage available.

a. The provisions governing clinical reviews for the determination of disability for non-LTSS, Community Medicaid are located in § 05-1.10 of this Chapter. For Medicaid LTSS, the provisions governing functional/clinical eligibility are set forth in Part 50-00-5 of this Title; for Katie Beckett eligibility, clinical reviews are conducted in accordance with Part 50-10-3 of this Title.

3.1.5 Income

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

1. Earned Income -- Earned income is income from work and may be in cash or in-kind and may include more of a person's income than he or she actually receives if amounts are withheld because of a garnishment or to pay a debt or other legal obligation, or to make any other payments. See § 3.3 of this Part for more detailed information.

2. Unearned Income – Unearned income is all income that is not earned through employment whether received in cash or in-kind. The provisions governing the counting of unearned income are also located in § 3.3 of this Part.

B. The rules governing the determination of countable income for IHCC category Community Medicaid members are in § 05-1.11 of this Chapter. ACA expansion adult provisions related to income are set forth in Part 30-00-3 of this Title.

C. Medically need (MN) eligibility is an option for applicants and beneficiaries who have income above the limits established in this Part. See Subchapter 05 Part 2 of this Chapter for non-LTSS MN; provisions pertaining to medically needy eligibility for Medicaid LTSS are located in Part 50-00-2 of this Title.

3.1.6 Resources

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

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

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

B. § 3.5 of this Part explains the types of resources and applicable exclusions in general when using the SSI method to determine financial eligibility. Subchapter 05 Part 1 of this Chapter focuses on Community Medicaid. Medicaid LTSS-specific provisions are located in Part 50-00-6 of this Title.

3.1.7 Income and Resource Standards

A. The following standards are used in the determination of the countable income and resources of an individual or couple when using the SSI method for determining Medicaid financial eligibility:

1. Monthly Federal Benefit Rate (FBR) – The FBR is set by the federal government and is based on the SSI monthly cash payment adjusted for living arrangement. Accordingly, the FBR serves as the SSI income eligibility standard and in the Medicaid eligibility determination process for calculating allowances and deeming purposes. The FBR is adjusted annually, as necessary, to reflect changes in the cost of living. The FBR is also the basis for the income eligibility cap for LTSS in certain circumstances.

Monthly Federal Benefit Rate (FBR) – 2019	
Living Arrangement	Monthly Payment
Individual - Own Home	$ 771
Couple - Own Home	$ 1157
Individual - Home of Another	$ 514
Couple - Home of Another	$ 771.34

Couple and Individual - Own Home	$ 386.52
Couple and Individual - Home of Another	$ 257.34

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

Optional State Supplement Payment (SSP) Limits: 2019		
Living Arrangement	Individual	Couple
Living in a residential care and assisted living facility	LTSS	Limited to Individuals only
– SSP Category D SSP per month up to $332 per month	$ 771 Maximum income eligibility is 300% of SSI rate $2,313	
	Community Medicaid	
SSP per month Category D up to $332 + SSI monthly rate	$ 1,103 Maximum federal and state payment	
LTSS Living in a Community Support Living Program residence (assisted living or adult supportive care homes)– Category F SSP per month up to $797 per month + SSI monthly rate	LTSS only $ 1,568 Maximum federal and state payment	Not Applicable
Living in own household SSP up to $39.92 (I) and $79.38 (C) + SSI monthly rate	$ 810.92	$ 1,236.38
Living in household of another	$ 565.92	$ 868.64

Optional State Supplement Payment (SSP) Limits: 2019		
Living Arrangement	Individual	Couple
SSP up to $51.92 (I) and $97.30 (C) + SSI monthly rate		
Living in a Medicaid-funded Institution Federal and State Supplement	$30 $50	$60 $100

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

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

(1) Subchapter 05 Part 2 of this Chapter covers Community Medicaid MN eligibility in detail. Under the RI Medicaid State Plan, MN coverage is available to elders and adults with disabilities, and MACC group parents/caretakers, children and pregnant women. There is no MN option for MACC adults, ages 19 to 64; members of this group who have a disability may apply through the EAD pathway and, if found to have a disability, may pursue Community Medicaid MN eligibility if they have income above 100 percent of the FPL. All MN beneficiaries are subject to the SSI method for determining eligibility, though income limits vary as indicated in the table below. Accordingly, for the purposes of determining eligibility, all are treated as members of the Community Medicaid group (hereinafter referred to as the Community Medicaid MACC group MN), even though the general population to which they belong is sometimes covered under a MACC group, using the MAGI-standard, such as children and pregnant women.

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

b. LTSS. Persons seeking Medicaid LTSS who have income above the eligibility limits, but below the cost of care at the average private pay rate established in the institutional cost of care comparison as set forth in §

3.1.7(A)(3)(d) of this Part below in an institution or HCBS setting also may seek MN eligibility. The MN eligibility period for LTSS is one month. The provisions governing MN eligibility for Medicaid LTSS are set forth in Part 50-00-2 of this Title.

c. MN Standards. Current MN income eligibility standards are as follows:

Medically Needy Income Standards (Income must be above to qualify)	
Coverage Group	Medically Needy Standard
Non-LTSS Elders and Adults with Disabilities & Refugee Medical Assistance	$ 917(Individual) $ 958 (Couple)
Medicaid LTSS (Excluding ACA expansion Adults)	Average Monthly Cost of LTSS (Private Pay)
Parents/Caretakers	146% FPL (Includes 5% disregard)
Pregnant Women	258% FPL (Includes 5% disregard)
Children Under Age 19	266% FPL (Includes 5% disregard)

d. Medicaid LTSS MN Institutional Costs Comparison. To be eligible for Medicaid LTSS as medically needy, an applicant/beneficiary must have countable monthly income above the federal cap (300 percent of the SSI rate) and below the average cost of LTSS, at the private pay rate, in the health institution (nursing facility, ICF/I-DD, or long- term hospital) that typically provides the level of care he or she is seeking. The health institution private pay rate applies irrespective of whether LTSS is or will be provided in the health institution or at home or in a community-based service alternative. The LTSS MN eligibility requirements are set forth in greater detail in Part 50-00-2 of this Title. The private pay rates established below are also used as the divisor to determine the length of a penalty resulting from a disqualifying transfer as indicated in § 50-00-6.6.1 of this Title. The average rates are as follows and take effect the first day of the month after the effective date of this regulation:

LTSS Medically Needy Eligibility Health Institution Costs – 2018-2019	
Health Institution	Average Private Pay Rate-Monthly/Daily
Nursing Facility, including skilled nursing	$9,581/$319
Intermediate Care Facility for persons with intellectual or developmental disabilities	$37,858/$1,261
Long-term care hospital	$45,599/$1,519

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

Federal Poverty Level (FPL) Income Limits All IHCC Groups	
Coverage Group	FPL Monthly Limits
Elders and Adults with Disabilities (EAD)	At or below 100% FPL
Community Medicaid Elders and adults with Disabilities Medically Needy (MN)	Above 100% FPL Spenddown to Medically Needy Income Limit
Refugee Medicaid Assistance (RMA) MN	At or below 200% FPL Spenddown to Medically Needy Income Limit
Community Medicaid MACC Group	Varies by population as indicated above

Federal Poverty Level (FPL) Income Limits All IHCC Groups	
Coverage Group	FPL Monthly Limits
MN	
QMB	100% Add $20
SLMB	120% Add $20
QI	135% Add $20
Sherlock Plan	250%
LTSS – SSI Pathway	Up to 300% SSI Level
LTSS – MAGI Pathway	Up to 133% of FPL and possible 5% disregard
LTSS Special Income/HCBS (217 lookalikes)	Up to 300% SSI Level
LTSS- MN Pathway	Up to cost of care

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

Resource Standards for IHCC Groups	
Coverage Group	Limits
Community Medicaid – EAD and MN	$4,000 (I) $6,000 (C)
Community Medicaid – MACC Group MN	Not Applicable
SSI –Protected Status	Varies by pathway. See § 05-1.5 of this Chapter
SSP – State Determination (EAD)	$4,000 (I) $6,000 (C)
SSP – SSA Determination	$2,000 (I) $3,000 (C)
Breast and Cervical Cancer	None
Refugee Medicaid	None
Sherlock Plan	$10,000 (1) $20,000 (C)
LTSS – SSI	$2,000
LTSS – Special Income/HCBS (217 lookalikes)	$4,000
LTSS – Medically Needy	$4,000
MPPP	Varies by pathway – See Chart in § 05-1.6 of this Chapter

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

Student Earned Income Exclusion		
Year	Monthly	Maximum in a Calendar Year
2019	$1,820	$7,350

2017	$1,790	$7,200

7. LTSS Spousal Impoverishment – Effective January 1, 2018 unless otherwise indicated

a. Minimum Monthly Maintenance of Need Allowance -- $2,057 (effective 7/1/2018)

b. Maximum Monthly Maintenance of Need Allowance -- $3,090.00

c. Community Spouse Monthly Housing Allowance -- $617.25 (effective 7/1/2018)

d. Community Spouse Resource Standards:

(1) Minimum -- $24,720

(2) Maximum -- $123,600

e. Home Equity Limit $585,000 (effective January 1, 2019)

8. Medically Needy Standards – Effective January 1, 2019

Family Size	MNIL Annual January 2019	Monthly 2019
1	$11,000	$917
2	$11,500	$958
3	$14,200	$1,183
4	$16,200	$1,350
5	$18,200	$1,517
6	$20,600	$1,717
7	$22,600	$1,883
8	$24,900	$2,075
9	$26,800	$2,233
10	$29,100	$2,425

a. For each family member above 10, add $175 to the monthly rate and multiply by 12 to obtain the annual MNIL.

3.2 SSI Methodology: Treatment of Income

3.2.1 Scope and Purpose

This section focuses on the treatment of income and, specifically, the way earned and unearned income are defined and evaluated when calculating countable income. For the purposes of this section, countable income is the total income available to a person seeking Medicaid benefits subsequent to the application of any required exclusions, disregards, and/or deductions and, as appropriate, deeming.

3.2.2 Definitions

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

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

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

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

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

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

6. "Non-applicant person" means a parent, child or spouse of the applicant in the IHCC group who is NOT applying for or receiving Medicaid health coverage, but whose finances are considered for the purposes of determining income and resources. For the purposes of Medicaid LTSS eligibility, the term "non-LTSS spouse" refers to the member of a couple who is not applying for or receiving Medicaid.

7. "Unavailable income" means the person cannot gain access to the income.

3.2.3 State Responsibilities

A. In calculating countable income, all sources of income a person receives or may be eligible to receive is reviewed. Not all sources of income are reviewed when renewing eligibility as indicated in § 3.2.5 of this Part. When determining initial eligibility using the SSI methodology, State responsibilities include, but are not limited to, the following:

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

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

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

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

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

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

3.2.4 Beneficiary Responsibilities

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

3.2.5 Types of Income

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

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

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

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

c. Federal, state or local tax refunds;

d. Interest on excluded resources;

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

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

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

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

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

j. Payments in cash or in-kind excluded by federal law, as indicated in subsection §§ 3.3 and 3.4 of this Part.

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

a. Employee income. When derived from –

(1) Commissions

(2) Severance pay, based on accrued leave time

(3) Tips

(4) Vacation donation compensation

(5) Wages

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

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

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

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

e. In-kind. Earned in-kind income is a non-cash payment a person receives in place of wages or money from self-employment. In-kind earned income

can be for food or shelter, such as free rent in exchange for apartment maintenance or items that could be sold or converted to obtain food or shelter. The current market value of earned in-kind income is countable, unless the exclusions in § 3.3.7 of this Part apply.

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

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

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

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

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

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

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

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

g. Foster care payments. When foster care payments are made under Title IV-E of the Social Security Act, they are countable income for the person

receiving care. Such payments are federally funded and thus the income is not subject to the $20 general disregard. See § 3.3.4(A)(8) of this Part for types of foster care payments that are not counted.

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

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

j. Irregular or infrequent lump sum. Unearned lump sum income that comes from an individual, organization, or investment if over $30 in a calendar quarter is counted. Treatment of lump sum income more generally is located in § 3.3.4 of this Part.

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

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

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

n. Retroactive RSDI. Lump sum payments are counted in the month received. See § 3.3.4 of this Part for information on the treatment of lump sum income more generally.

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

p. Spousal maintenance or allowance.

q. Student financial aid, in the following situations:

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

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

r. Tribal per capita payments from casinos.

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

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

3.3 Factors Considered in the Treatment of Income

3.3.1 Scope and Purpose

When calculating countable income using the SSI methodology, certain disregards and exclusions apply: some only to earned income, others only to unearned income, and a few apply to both earned and unearned income. The availability of income also affects whether it is counted. This section focuses on these and any other factors considered in the treatment of income for Medicaid eligibility purposes across populations. The specific rules for how they apply when determining income eligibility for Community Medicaid are located in Subchapter 05 Part 1 of this Chapter; for Medicaid LTSS, all special provisions that apply are located in §§ 50-00-6.2 to 6.12 of this Title.

3.3.2 Both Earned and Unearned Income Disregards and Exclusions

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

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

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

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

c. A "calendar quarter" is defined in § 1.4(A)(3) of this Subchapter.

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

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

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

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

4. Federally Mandated Exclusions – Certain federal laws other than the U.S. Social Security Act exclude various types of earned and/or unearned income from the calculation of countable income in the financial eligibility process. A list of these exclusions is located in § 3.3 of this Part and is updated on a periodic basis.

3.3.3 Earned Income Disregards and Exclusions

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

1. $65 and 1/2 Earned Income Disregard – If the applicant or non-applicant spouse is employed, earned income of $65/month plus one half (1/2) of the

balance is disregarded. When both eligible spouses are employed, income is combined and then the disregard is applied.

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

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

4. Earned Income Tax Credit/Refund – The earned income tax credit (EITC) is not counted, The EITC is a special tax credit for certain low income working taxpayers authorized that may be provided as refund through the federal Internal Revenue Service under of the Internal Revenue Code (IRC), 26 U.S.C § 32 or as an advance payment from an employer under 26 U.S.C § 3507. The EITC may or may not result in a payment to the taxpayer.

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

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

b. The expense must be reasonable;

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

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

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

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

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

3.3.4 Unearned Income Disregards and Exclusions

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

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

2. Burial Funds – Interest earned on the value of excluded burial funds is excluded from income (and resources) if left to accumulate in the burial fund. Interest earned on agreements representing the purchase of an excluded burial space is excluded from income (and resources) but only if left to accumulate. If not left to accumulate – that is, paid directly to the person, spouse or parent - the receipt of the interest may result in countable income.

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

a. Court ordered health care support payments;

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

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

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

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

b. Lump sum death benefit from SSA;

c. Railroad Retirement burial benefits;

d. VA burial benefits;

e. Inheritances in cash or in-kind;

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

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

5. Disaster Assistance – At the request of a state governor, the President may declare a major disaster when the disaster is of such severity and magnitude that effective response is beyond the capabilities of the state and local governments, and federal assistance is needed. Under such circumstances, the value of disaster assistance provided by a government agency or an organization such as the Red Cross is excluded from countable income if the person resided in permanent or temporary housing in the disaster area prior to the date of the Presidential designation.

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

a. The United States Housing Act of 1937, 42 U.S.C. § 1437;

b. The National Housing Act, 12 U.S.C. § 1715;

c. Section 101 of the Housing and Urban Development Act of 1965, 12 U.S.C. § 1701s;

d. Title V of the Housing Act of 1949, 42 U.S.C. § 1471; or

e. Section 202(h) of the Housing Act of 1959, 12 U.S.C. § 1701q.

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

8. Foster Care Payments – In contrast to countable payments made under 45 C.F.R. Part 1356 (Title IV-E), Foster Care payments provided under the Social Security Act, 45 C.F.R. Part 1357 and 45 C.F.R § 96(G) (Title IV-B or Title XX) are social services and are excluded from the foster child's income.

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

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

11. Home Energy Assistance Payments – Home energy or support and maintenance assistance is excluded if it is based on need and provided in- kind by a private nonprofit agency or in cash or in-kind by a supplier of home heating oil or gas, a utility company providing home energy, or a municipal utility providing home energy.

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

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

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

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

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

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

d. Agent Orange settlement payments.

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

16. Student Loans – Federal and State funds or insurance are provided for educational programs at middle school, secondary school, undergraduate and graduate levels under Title IV of the Higher Education Act, 20 U.S.C. Parts 1070 through 1099d and student assistant programs of the Bureau of Indian Affairs. Any loan to an undergraduate student for qualified education expenses made and/or insured by the federal government or the State's higher education financing authority is excluded as both an income and resource.

3.3.5 Lump Sum Income Disregards and Exclusions

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

1. Winnings (lottery, gambling), Insurance settlements

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

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

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

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

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

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

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

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

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

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

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

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

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

3.3.6 Self-Employment Income

A. Self-employed beneficiaries are responsible for their own work schedules and are not covered under an employer's liability insurance or Workers' Compensation. Depending on the type of self-employment, a beneficiary may or may not have Social Security tax (FICA) deducted from pay. Examples of self-employment enterprises include, but are not limited to: Farming; Product Sales (involving personal goods such as jewelry, household goods, clothing and the like); Personal Training; Professional Consulting; Small

businesses; Services (personal care or day care); and Skilled Trades (roofers, painters, home design, etc.). The process for evaluating self-employed income includes:

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

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

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

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

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

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

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

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

c. In-home Day Care. When a person provides family child care services in a home in which he or she has an ownership interest, net self-employment income is countable. In such instances, allowable expenses are itemized as business expenses for tax filing purposes and include food (meal and snacks) and educational and entertainment materials in addition

to transportation and shelter costs. If the care is provided in a home in which there is no ownership interest, the applicant/beneficiary is treated as a private contractor and these additional allowable expenses are not deducted from gross employment income. Payments made by the DHS to an in-home child care provider in association with the State's Child Care Assistance Program (CCAP) are countable.

3.3.7 In-Kind Income

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

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

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

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

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

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

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

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

3.3.8 Availability

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

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

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

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

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

3.4 Federally Mandated Income Exclusions

Federally Mandated Income Exclusions
Agent orange settlement payments;
Child care assistance under the Child Care and Development Block Grant Act of 1990 (as in effect on September 1, 2018);
The first two thousand dollars per calendar year received as compensation for participation in clinical trials that meet the criteria detailed in section 1612(b) of the Social Security Act (September 1, 2018);
Payments made for supporting services or reimbursement of out-of-pocket expenses to volunteers participating in corporation for national and community service (CNCS, formerly ACTION) programs: AmeriCorps program; Special and demonstration volunteer program; University year for ACTION (UYA);
Retired senior volunteer program (RSVP);
Foster grandparents program;

Federally Mandated Income Exclusions
Senior companion program;
Energy employees occupational illness program payments;
Federal food and nutrition programs:
Food assistance (formerly known as food stamps) U.S. department of agriculture food commodities distributed by a program (private or governmental); School breakfast, lunch, and milk programs; Women, infants, and children program (WIC); Nutrition programs for older Americans
Student financial assistance received under the Higher Education Act of 1965 (as in effect on September 1, 2018) or Bureau of Indian Affairs is excluded from income and resources, regardless of use: Pell grants; Student services incentives; Academic achievement incentive scholarships; Byrd scholars; Federal supplemental education opportunity grants; Federal educational loans (federal PLUS loans, Perkins loans, Stafford loans, Ford loans, etc.); Upward bound; Gear up (gaining early awareness and readiness for undergraduate programs); State educational assistance programs funded by the leveraging educational assistance program;

Federally Mandated Income Exclusions
Work-study programs.
Home energy assistance provided on the basis of need, in accordance with 20 C.F.R. § 416.1157 (as in effect on September 1, 2018);
Matching funds that are deposited into individual development accounts (IDAs), either demonstration project or TANF-funded, in accordance with 42 U.S.C. § 604 (as in effect on September 1, 2018);
Japanese-American and Aleutian restitution payments;
Payments to victims of Nazi persecution;
Netherlands WUV payments to victims of persecution from 1940-1945;
Department of defense payments to certain persons captured and interned in North Vietnam, in accordance with the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act of 1998 (as in effect on September 1, 2018);
Radiation exposure compensation trust fund payments, in accordance with the Radiation Exposure Compensation Act of 1990 (as in effect on September 1, 2018);
Veterans affairs payments made to or on behalf of:
Certain Vietnam veterans' natural children regardless of or age or marital status, for any disability resulting from spina bifida suffered by such children; Certain Korea service veterans' natural children regardless of their age or marital status, for any disability resulting from spina bifida suffered by such children; Women Vietnam veterans' natural children regardless of their age or marital status, for certain birth defects;
Austrian social insurance payments received under the provisions of the Austrian General Social Insurance Act, 20 U.S.C. § 1613(a), 20 C.F.R. § 416.1236 (as in effect on September 1,2018). These payments must be documented and identifiable from countable insurance;

Federally Mandated Income Exclusions
Payments made to Native Americans as listed in section IV of 20 C.F.R § 416(K) Appendix (as in effect on September 1, 2018);
Payments from the Ricky Ray hemophilia relief fund or the class settlement in the case of Susan Walker v. Bayer Corporation, et al. under the Ricky Ray Hemophilia Relief Fund Act of 1988 (as in effect on September 1, 2018).

3.5 SSI Methodology: Treatment of Resources

3.5.1 Scope and Purpose

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

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

2. Comprehensive Resource Review for LTSS – There are both MAGI and SSI-related eligibility pathways for LTSS that differ in terms of the treatment of income and resource limits, at least at the point in which an institutional level of care becomes required. Applicants evaluated using the SSI method (IHCC groups) are subject to a resource review and, in some instances, using specialized criteria as indicated in § 50-00-6.3 of this Title; the resources of applicants seeking coverage through a MAGI pathway (MACC groups) are not an eligibility factor and therefore are not considered on that basis. However, all LTSS applicants, irrespective of eligibility pathway, are subject to an in-depth review of

the transfer of assets – including income and resources – to ensure that the rules are applied equitably and in accordance with the standards set in federal and state laws and regulations governing estate recovery. The specific provisions applicable to the evaluation of resources and transfers if assets for Medicaid LTSS are set forth in § 50-00-6.6 of this Title.

3.5.2 Definitions

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

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

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

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

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

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

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

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

8. "Intent to return" means an expression by a person indicating that he or she plans to live in the home used as the principal place of residence after a temporary

absence. The intent to return home is subjective rather than objective and, as such, must be expressed by the applicant or beneficiary, or an authorized representative, and take the form of a signed, written statement.

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

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

11. “Non-liquid resources” means property that is not cash, including real and personal property that cannot be converted to cash within twenty (20) working days.

12. “Ownership interest” means the person seeking Medicaid holds sole or joint legal title to the residential property or is a party to a legal covenant establishing property ownership, such as a life estate.

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

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

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

16. “Resource transfer” means the conveyance of right, title, or interest in either real or personal property from one person to another. The conveyance may be by sale, gift, or other process.

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

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

3.5.3 State Responsibilities

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

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

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

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

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

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

d. Countable v. Excluded Resources. A resource is may be counted or excluded when determining financial eligibility. The State must consider whether a resource is counted or subject to a general or coverage group-specific exclusion and then assure any applicable exclusions are considered as follows –

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

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

3. Deemed Resources – non-LTSS only – The resources of members of the FRU must also be evaluated and any that are countable attributed to the applicant(s) in the deeming process in accordance with Subchapter 05 Part 1 of this Chapter. For Medicaid LTSS, there is no deeming and the evaluation of resources is always based on the applicant or individual - that is, an FRU and Medicaid eligibility unit size of one – unless both spouses are seeking coverage subsequent to the initial determination of eligibility.

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

3.5.4 Beneficiary's Responsibilities

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

3.5.5 Types of Resources and Related Exclusions

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

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

a. Home and Adjoining Land (real property). A home is a residential property which includes the shelter where a person lives, the land on which the shelter is located, related outbuildings, and surrounding property not separated from the home by intervening property owned by others. Public rights of way, such as roads that run through the surrounding property and separate it from the home, do not affect the exemption of the property. A home in which the applicant or the spouse of an applicant has an ownership interest is excluded as resource, regardless of its value, for EAD or MN Community Medicaid. A home is also excluded for LTSS, but only up to the equity value limits established in § 3.1.7(A)(7)(e) of this Part and the provisions set forth in § 50-00-6.5.3 of this Title with respect to the intent to remain are met. Factors affecting application of the exclusion include -

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

(2) Multiple Residences. Although an applicant may own residential properties either alone or in conjunction with others, only one is considered a home and may be treated as an excluded resource at any given point in time. Even in situations in which both spouses in the household are applicants, the value of only one home may be excluded. When the person and his/her spouse/dependent child make conflicting claims over which residential property is subject to the home exclusion the following decision rules apply:

> (AA) If the applicant and applicant's spouse live in separate residential properties in Rhode Island in which they share ownership, the home exclusion applies to the residential property where the person lived at the time the application for Medicaid health coverage was received by the State.
>
> (BB) If each spouse lives in a separate residential property in Rhode Island, in which they share ownership, and both spouses apply for Medicaid, the home exclusion applies to the property where the spouse who applied first resides.
>
> (CC) If both spouses apply on the same day, the spouses must agree in writing which home is to be excluded. If no agreement can be reached, the home exclusion is applied to the residential property with the greatest value.

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

(4) Multi-State Residences – When a person owns residential properties both in and out-of-state, the home exclusion is applied to the residential property located in Rhode Island. The value of any out-of-state residential property is a countable resource, even if it is the principal place of residence of the applicant's

spouse/dependent child, as long as the applicant maintains an ownership interest in any Rhode Island residential property.

(5) Out-of-State property owner – If the person does not own residential property in Rhode Island but lives and intends to remain in the state, the home exclusion may be applied to an out-of-state residential property if, and only if, it is the principal place of residence of the person's spouse or dependent child.

(6) Sale of the Home – The home exclusion remains in effect if the Medicaid beneficiary or spouse with an ownership interest is making an effort to sell the home. For Medicaid LTSS purposes, the provisions in § 50-00-6.5.3(B)(2)(c) of this Title apply if the home serves as the principal place of residence for an applicant or beneficiary. If efforts to sell a home that is not or no longer meets the criteria to be excluded under this subpart are unsuccessful, the value of the home is treated as a countable resource unless documentation of such efforts is provided by a competent authority such as an attorney or real estate broker. Even when such documentation is provided, there is a limit on the length of time the resource is treated as unavailable as indicated in § 50-00-6.5.4 of this Title.

(7) Proceeds from the Sale – Once a home has been sold, the proceeds are excluded for six (6) months from the date they are received for Community Medicaid eligibility in accordance with Subchapter 05 Part 1 of this Chapter. Unless obligated or used for the purchase, repair or construction of another domicile or another excluded resource, the proceeds become countable on the FOM in the month after the sale Medicaid LTSS eligibility.

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

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

(BB) Has a spouse or dependent residing in the home; or

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

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

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

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

e. Life estate (real property). Life estate means a legal arrangement entitling the owner of the life estate (sometimes referred to as the “life tenant”) to possess, rent, and otherwise profit from real or personal property during their lifetime. The amount of a life estate that is countable depends on when it was established, whether the applicant(s) have the legal right to sell the home, and the portion of the proceeds of the sale, if allowed, is available. The owner of a life estate sometimes may have the right to sell the life estate but does not normally have future rights to the property. Life estates are only excluded in full when the owner retains the power to sell or mortgage the home. If the owner does not retain this right, the provisions in § 50-00-6.9.1 of this Title apply.

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

> (1) Burial fund exclusion (BFE). The BFE allows an individual to exclude up to $1,500 of resources for services including preparing the body for burial and services that are not performed at the burial site; the exclusion for a couple is $3,000; and for a person seeking MN eligibility is $4,000. These resources must be clearly designated for the person or their spouse’s burial, cremation, or other burial-related services; they cannot be commingled with other resources intended for burial. This exclusion applies only if the funds set aside for burial expenses are kept separate from all other resources not intended for burial. The BFE is reduced by the

face value of any whole life insurance policy excluded under this section as well as any amounts for such services covered in a revocable burial contract.

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

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

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

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

h. Life Insurance Policy. A contract between the policy holder and an insurer in which the insurer agrees to pay a designated beneficiary a sum of money in exchange for a premium, upon the death of the insured person – in this case the applicant/beneficiary (often the policy holder). Whole

life insurance is permanent and builds cash value over the insured person's lifetime because it has an added investment component along with its death benefit. The value of a whole life insurance policy is only counted if the person, or the person's spouse (couple) is the owner. Policies on the life of a person or applicant's spouse owned by another member of the FRU are not considered even when deeming applies (non-LTSS). Whether a policy is counted as resource depends on two factors:

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

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

(3) Counting rule. If the total face value of all life insurance policies on any person is at or below $4,000, no part of the cash surrender value of the life insurance is included when determining countable resources. If the face value is above $4000 only the cash surrender value above $4,000 is a countable resource. The total amount of the cash surrender value above $4000 is added to all other countable resources when determining whether an applicant or beneficiary is at or below the resource limit for Medicaid financial eligibility. The cash surrender value below $4000 is treated as an unavailable resource unless or until the policy is cashed out. Term insurance and burial insurance are not taken into account.

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

a. Annuities. A contract reflecting payment to an insurance company, bank, charitable organization, or other registered or licensed entity; it may also be a private contract between two parties. The purchase of an annuity may constitute a disqualifying transfer that results in a period of ineligibility for seeking initial or continuing Medicaid LTSS. The applicable provisions related to asset transfers are set forth in § 50-00-6.7 of this Title. In addition, there are two phases to an annuity, each of which also affects how it is treated as resource: an accumulation phase and a payout phase. Annuities also vary significantly by type, how beneficiaries are treated, and how they accumulate and pay out money, such as lump sum v. scheduled, usually on a monthly basis. All these factors influence

whether the value of the annuity is counted or excluded. In addition, the State considers whether the annuity is a liquid resource, and ownership. Since annuities are trust-like instruments, terminology similar to trusts is used when it describes the availability of cash from annuities. The amount of any penalties paid when cashing-in an annuity is deducted from the amount of the payout. In general, exclusions are as follows:

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

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

(3) Treatment by Phase. An annuity owned by a person seeking Medicaid is a countable resource in its accumulation phase because it can be liquidated for a lump sum or sold. An annuity in its pay-out phase is considered an excluded resource if the person only has the right to liquidate the annuity for the present value of all future payments and this commuted value is less than its equity value.

b. Cash and Accounts in Financial Institutions. Cash on hand is a countable resource. In addition, accounts held in financial institutions – checking and draft accounts, savings and share accounts, money market account, and certificates of deposit – are all countable resources for both the person seeking Medicaid and members of the FRU for deeming purposes. In instances in which an account is jointly held, the value is apportioned equally among owners unless there is a title or deed to the contrary. In cases in which there is ownership in common or in entirety, the provisions in § 3.6.2(A)(4) of this Part apply. For the purposes of calculating Medicaid LTSS eligibility, an applicant who is a joint owner of an account is presumed to be legally able to withdraw and obtain unrestricted access to funds in the account. An applicant may rebut this presumption by providing documentation such as a deed or title. Absent such documentation, the full value of the account is treated as a countable resource when determining financial eligibility including allocation of resources for Medicaid LTSS eligibility in accordance with § 50-00-6.5.2(D) of this Title.

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

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

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

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

(4) Availability. The value of a jointly owned investment, account or holding is considered unavailable and does not count toward the resource limit, if it cannot be redeemed or sold because the co-owner cannot be located or refuses to cooperate by providing a necessary signature/authorization or, in the case of a bond, the paper bond or access to electronic transaction authority.

d. Loans. A loan is an oral or written contract or statement clearly indicating a borrower's indebtedness, the personal or real property used to secure the borrowed amount (collateral), if any, and the terms of repayment. Loans may be made through commercial entities including financial institutions and informally between persons and entities. The treatment of loans depends on whether it is "bona fide" – that is, the terms of the loan agreement are made in good faith and are enforceable under applicable state law (the borrower can be sued if the loan is not paid back), the agreement is in effect at the time the lender transfers funds, the loan is secured, and the borrower agrees to the terms of repayment. Any loan that is not bona fide may be treated as a gift, unless it qualifies as a promissory note under § 3.5.5(A)(2)(f) of this Part below; in such instances, the full value of the loan may be counted as income and/or a resource depending on whether the applicant is the lender or borrower and the manner in which it is paid. In addition, such loans may be considered a disqualifying transfer for Medicaid LTSS purposes if their fair market value cannot be discerned in accordance with § 50-00-6.8 of this Title. In general, unless explicitly excluded as a resource under § 3.6.4 of this Part, bona fide loans are treated as follows for the lender or borrower:

(1) Borrower. The amount of the loan that the borrower must repay, along with any interest, is excluded as a countable resource in the month the loan is executed. Any portions of the loan

remaining on the FOM after the month it is executed is a countable resource.

(2) Lender. The amount the lender loans and the loan repayments may be treated as countable resources depending on the circumstances of its execution. If a loan is negotiable and can be sold or discounted on the open market it is considered a countable resource. Interest is always treated as unearned income; principal payments are the conversion of a resource and are not treated as income.

e. Mortgages. A debt instrument, secured by the collateral of specific piece of real estate property, that a borrower is obliged to pay back without paying the entire purchase price upfront by making a predetermined set of payments. A borrower is considered an owner of a mortgaged property for the purposes of determining Medicaid eligibility. The purchase of a mortgage may be treated as a disqualifying transfer for Medicaid LTSS purposes if made for less than fair market value in accordance with § 50-00-6.8 of this Title.

f. Promissory notes. A promissory note is a written, unconditional agreement, usually given in return for goods, money loaned, or services rendered, whereby one party promises to pay a certain sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered to the owner of the agreement (the seller). A promissory note is a liquid resource. The property itself is not a resource because the seller cannot legally convert it to cash while it is encumbered by the agreement. If payments received by the seller consist of both principal and interest, only the interest portion is income. The principal portion the promissory note is the conversion of a resource and is not income but is an available resource unless it is non-negotiable and the person provides evidence of a legal bar to the sale of the promissory note. Treatment of a promissory note for Medicaid LTSS eligibility related to the transfer of assets is located in § 50-00-6.8 of this Title.

g. Retirement funds. Any resource set aside by a person to be used for self- support upon their withdrawal from active life, service, or business. Retirement funds include, but are not limited to, certain IRAs, Keogh plans, 401K plans, pensions, mutual funds, stocks, bonds, securities, money market accounts, whole life insurance, and retirement annuities. The value of a retirement fund is the amount of money that can currently be withdrawn from the fund, less any penalties for withdrawal. An applicant or beneficiary who owns a retirement fund must apply for such funds or liquidate the fund. Retirement funds are excluded when owned by either the person seeking Medicaid or a spouse when the couple is living together and: termination of employment is required to obtain a payout

from the fund; the owner is not eligible for periodic payments and does not have the option of withdrawing a lump sum; or either spouse is eligible for periodic payments and is drawing down on the fund at a rate consistent with their life expectancy. When funds are being drawn down, the payout is treated as countable income for financial eligibility purposes and there is no deeming under § 05-1.11.2 of this Chapter or attribution under § 50-00-6.5.2 of this Title to a non-applicant spouse or child. In instances in which the retirement accounts are countable as resource, the amount counted is the amount that can be withdrawn from the account, less any penalties. Any taxes owed as a result of the withdrawal are not deducted when determining the countable value of the retirement fund. Medicaid LTSS-specific provisions related to the treatment of retirement funds for the purposes of the community spouse resource allocation and the transfer of assets are located in § 50-00-6.5.3.

h. Education funds. Resources set aside to pay for qualified education expenses such as 529 accounts and Coverdell Educational Savings Accounts. The full amount of such funds is excluded as a resource and are unavailable for deeming in the determination of financial eligibility when the monies deposited into the account are for the qualified educational expenses of the applicant or beneficiary, or his or her non-LTSS spouse, or dependent(s). Distributions are excluded as income when made for qualified educational expenses, even if the applicant or beneficiary as co-owner must consent to the release of funds and/or receives the distribution and provides the payment or receives reimbursement for the qualified education expenses of the spouse or dependent(s). Third-party contributions to an education fund made by an applicant or beneficiary, in which he or she is not the named co-owner are considered gifts. For the purposes of Medicaid eligibility in Rhode Island, such contributions are excluded providing the amount does not exceed the limit for the special deduction permitted under RI tax law of $500 for an individual and $1,000 for a couple even if the beneficiary is a member of the FRU.

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

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

1. Guardianship/Conservator funds -- A person or institution appointed by a court in any state to act as a legal representative for another person, such as a minor or a

person with disabilities. Cash or funds held by a guardian or conservator in bank or similar financial institution are presumed to be available for the support and maintenance of the protected person and, are countable resources. Other resources of the person subject to a guardianship or conservatorship, such as real estate, brokerage accounts, stocks, bonds, life insurance policies, and automobiles, are presumed to be unavailable due to a legal impediment and are not countable resources for the purposes of determining Medicaid eligibility. Such other resources may become available, when the guardian or conservator is required as a condition of obtaining or maintaining the person's Medicaid eligibility to seek Court approval to liquidate and convert assets into cash or funds in a bank or similar account accessible available for the person's support and maintenance.

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

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

4. Trust -- A property interest that usually takes the form of fund comprised of a variety of liquid and non-liquid resources, including but not limited to, cash, stocks, bonds, personal effects, life insurance, business interests, and real estate – that is held by a person or entity (called a "trustee") who is legally responsible for ensuring the property owned by trust is used to benefit another person (the "trust beneficiary). The person who transfers the resources to the trust is known as the "grantor." In some instances, the grantor is also named as a trust beneficiary or "grantee." The treatment of a trust for Medicaid eligibility purposes depends on its type, whether the property it holds is accessible, and who is the grantor, grantee and/or trustee. In general, the treatment of trusts is determined in accordance with § 50-00-6.11 of this Title.

3.6 Factors Considered in the Treatment of Resources

3.6.1 Scope and Purpose

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

3.6.2 Process Rules

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

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

2. Resource Changes – What a person owns in countable resources can change during a month, but the change is always effective with the following month's resource determination. The kinds of changes that may occur include:

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

b. Disposition or acquisition of resources. A person may dispose of an existing resource, such as close a savings account and purchase an item, or may acquire a new resource, such as an inheritance which is subject to the income-counting rules in the month of receipt).

c. Change in exclusion status of existing resources. A person may replace an excluded resource with one that is not excluded, such as sell an excluded vehicle for non-excluded cash, or vice versa (use non-excluded cash to purchase an excluded automobile). Similarly, a time-limited exclusion (such as the period for exclusion of retroactive Title II – RSDI – benefits) may expire.

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

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

In general, allowable expenses for resource reduction include:

a. Health care services that are not covered under the Medicaid State Plan and the State's Section 1115 demonstration waiver and are not reimbursable by a third- party such as Medicare, or some form of insurance. Such expenses must occur in a month of eligibility, including periods of retroactive eligibility when applicable. Certain LTSS home health care services are allowable expenses for Community Medicaid applicants when delivered by certified providers but only up to the amount Medicaid pays for the same or similar services on a fee-for-service basis. Additional rules apply for Medicaid LTSS and are available at § 50-00-6.5.5 of this Title.

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

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

d. Legal fees associated with disposing or gaining access to resources.

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

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

b. Jointly Owned Resources. When two or more parties share rights to sell, transfer, or dispose of part or all of personal or real property, the ownership share held by each person must be evaluated. This rule applies to resources such as joint checking or savings accounts and real estate held in common. In instances in which the document creating the joint interests, such as a deed to real estate or a bank account signature card, specifies the shares of the parties, the fair market value of the entire resource is divided between the joint owners according to the shares specified. The factors related to the availability and salability of jointly owned resources are taken into account in this review process. In instances in which a co-owner who must consent to the sale or redemption of a jointly owned resource is unavailable or refuses to take the actions necessary for the sale or redemption of the resource, then the resource is considered unavailable and is not included in the calculation of countable resources. Attribution of jointly owned resources is otherwise determined as indicated below:

(1) Tenancy in common. Applies to all jointly owned resources involving two or more persons which do not specify the ownership portion of each party – as in cases of joint tenancy or tenancy in its entirety. When the person seeking Medicaid and/or spouse has a tenancy in common with someone outside the household, the total value of non-liquid resources is divided among the total number of owners in direct proportion to the ownership interest held by each.

By contrast, when a liquid resource such as an account in a financial institution is held in common, the entire equity value of funds in the account is considered available to its owner.

(2) Joint tenancy. Occurs when each of two or more persons has one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. In effect, each owner owns all of the property. One owner may sell, transfer or otherwise dispose of his or her share of the property without permission of the other owner(s) but cannot take these actions with respect to the entire property. Upon death of the joint tenant, title automatically vests in the surviving joint tenant. While alive any joint tenant may convey the interest held to a third party. After such a conveyance, the new parties own the property as tenants in common.

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

(4) Proportional joint ownership. The value of shared property in which each person only owns his or her fractional interest in the property is determined by dividing the total value of the property among all the owners in direct proportion to the ownership share held by each.

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

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

5. Legal Factors Affecting Availability – A court restriction may make all or part of the resource unavailable. Other legal restrictions on resources may be included in: liens, domestic orders, divorce decrees, child support orders, probate matters, tax intercepts and garnishments, and/or bankruptcy proceedings. Other factors affecting the availability of a resource are specified below in paragraph (6) and for LTSS eligibility purposes in § 50-00-6.5.4 of this Title.

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

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

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

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

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

3.6.3 Mandatory Resource Exclusions

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

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

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

3.6.4 Special and Limited Time Exclusions

A. There are a number of special and time-limited exclusions that apply across the IHCC groups as well. Applicable general time-limited exclusions are as follows:

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

2. Funds for Replacing Excluded Resources – Cash and interest earned on that cash are excluded when received from any source, including casualty insurance,

when it is for the purpose of repairing or replacing an excluded resource that is lost, stolen, or damaged. The exclusion is allowed for nine (9) months from the month of receipt of such funds and may be extended for an additional nine months for good cause.

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

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

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

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

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

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

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

purposes other than qualified home repairs or modifications are counted as a resource on the first day of the month following the renewal date.

10. ABLE accounts – The federal Achieving a Better Life Experience Act (ABLE) of 2014 amends Section 529 of the IRS code to permit states to create tax-advantaged savings accounts for persons who have proof of a documented disability or blindness, the onset of which occurred before age twenty-six (26). In accordance with R.I. Gen. Laws § 40-7.2-20.1 *et seq.,* balances held in an ABLE account are excluded when determining financial eligibility for non-LTSS Medicaid under this Part and Medicaid LTSS pursuant to Part 50-00-6 of this Title. For persons eligible for Medicaid based on receipt of Supplemental Security Income (SSI), as described in Part 05-1 of this Chapter, balances of up to $100,000 are excluded in the determination of financial eligibility. An SSI recipient with an ABLE account in excess of this balance loses SSI cash benefits until the balance is below this limit but is deemed eligible for the purposes of maintaining Medicaid eligibility. The resource exclusion for Medicaid eligibility continues to apply unless or until the contributions for the person benefiting from the ABLE account exceeds the annual limit of $15,000 or the maximum life-time limit of $395,000. ABLE accounts are managed by the State and funds must be used only for the Qualified Disability Expenses established in federal and State laws. Additional information on ABLE accounts is located at the RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) website at: http://www.bhddh.ri.gov/developmentaldisabilities.

3.6.5 Determination of Resource Eligibility

Once the appropriate exclusions have been applied and the value of each type of resource is determined, the value of all countable resources (including deemed resources) are added together to determine the total countable resources for the Medicaid eligibility group for the family size involved. If the resources of the Medicaid eligibility unit fall below or are equal to the applicable eligibility resource standard, the resource test is passed. If an excess resource amount remains after all exclusions have been applied, the applicant/beneficiary has not passed the resource test and must either reduce resources in accordance with the applicable provisions in § 3.6.2(A)(3) of this Part or give away excess resources subject to the transfer of resources rule for Medicaid LTSS set forth in § 50-00-6.6 of this Title.

3.7 Federally Mandated Exclusions

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

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

Federally Mandated Resource Exclusions
Blood Product Settlement payments
Corporation for National and Community Service (CNCS) payments. Payments to volunteers, including the following payments authorized under the Domestic Volunteer Services Act, are excluded: AmeriCorps Urban Crime Prevention Program Special Volunteer Programs under Title I Demonstration Programs under Title II Senior Corp: Retired Senior Volunteer Program (RSVP) Foster Grandparent Program Senior Companions
Individual Development Accounts (IDA)
Japanese and Aleutian Restitution payments
Jensen Settlement Agreement payments. Payments received by class members are excluded. Funds received under this agreement from countable resources at the time of application and at each renewal are deducted.
Low Income Home Energy Assistance Program (LIHEAP) payments
Nazi Persecution payments
Radiation Exposure Compensation Trust Fund (RECTF) payments
Real estate taxes, homeowner's insurance and funds set aside for upkeep expenses of the property. Up to one year's expenses are excluded. Funds must be kept in a separate account.
Relocation Assistance payments, federal
Ricky Ray Hemophilia Relief Fund payments

Federally Mandated Resource Exclusions
Student financial aid received under Title IV of the Higher Education Act or Student financial aid received from the Bureau of Indian Affairs (BIA) Non-Title IV and non-BIA grants, scholarships, fellowships and other non-loan financial aid, if used or set aside to pay educational expenses until the month following the last month the student is enrolled in classes. Distributions from a Coverdell Educational Savings Accounts (ESA) if the funds are used for educational expenses. Excluded for the designated beneficiary of the account for nine months following the month of receipt of a distribution. Excluded for anyone who is not a beneficiary who contributes money to the account beginning the month after the month the funds are transferred into the account. Excluded, due to being a conversion of a resource, for a contributor who is the designated beneficiary beginning with the month after the month the cash is transferred into the account. Veteran's Affairs (VA) benefits designated as educational assistance both under graduate and graduate students until the month following the last month the student is enrolled in classes. Plan to Achieve Self Support (PASS) student financial aid. Training expenses paid by the Trade Adjustment Reform Act of 2002 Qualified Tuition Programs (QTP), also known as a 529 Plans, for the designated beneficiary (the student or future student) who is not the owner of the account and does not have any rights to the funds in the account.
Tribal payments and interests. The following tribal resources are excluded. Tribal trust or restricted lands, individual interest Tribal per capita payments from a tribal trust Tribal land settlements and judgments
Uniform Gift to Minors Act/Uniform Transfers to Minors Act (UGMA/UTMA) The full value of resources established under the UGMA/UTMA is excluded.

Federally Mandated Resource Exclusions
An adult designated to receive, maintain and manage custodial property on behalf of a minor beneficiary is not the owner of UGMA/UTMA resources because the adult cannot legally use any of the funds for his or her support and maintenance. When the UGMA/UTMA property is transferred to a beneficiary at the end of the custodianship (usually at the age of 18 or 21 depending on state law) the property becomes available to the beneficiary. It is counted as income in the month of transfer and as a resource in the following month.
Veterans' Children with Certain Birth Defects payments
Vietnamese Commando Compensation Act payments
Excluded Resources Regardless of Identifiability (unless otherwise noted)
Adoption Assistance payments are excluded in the month of receipt and thereafter.
Accrued Interest on resources is excluded if any excess is properly reduced at eligibility redetermination.
Alaska Native Claims Settlement Act (ANCSA) payments
Appeal Payments are excluded as resources in the month received and for three months after the month of receipt.
Clinical trial participation payments excluded by SSI. The first $2,000 a person receives during a calendar year is excluded.
Cobell Settlement for American Indians for a period of 12 months beginning with the month of receipt. This exclusion applies to all household members.
Crime victim payments
Disaster assistance, federal payments
Disaster assistance, state payments
Filipino Veterans Equity Compensation (FVEC) payments
Foster Care payments

Federally Mandated Resource Exclusions
Gifts to Children with Life Threatening Conditions from 501(c)(3) tax-exempt corporation. These are not considered resources of a parent and apply only to children who are under age 18. Cash gifts up to $2,000 in any calendar year are excluded. The amount of total cash payments that exceed $2,000 each year are counted as a resource. Multiple cash gifts in the same calendar year are added together and up to $2,000 of the total is excluded, even if none of the cash gifts exceeds $2,000 individually.
Homestead real property
Household goods and personal effects
James Zadroga 9/11 Health and Compensation Act of 2010
Kinship payments
Proceeds from the Sale of a Homestead are excluded if a person: Plans to use the proceeds to buy another homestead, and Does so within three full calendar months of receiving the funds
Reimbursements for replacement of lost, damaged or stolen excluded resources are excluded for the month of receipt and nine months thereafter. The funds are excluded for up to nine more months if the person tries to replace the resources during that time, but cannot do so for good reason.
Representative Payee Misuse payments. If a person's Supplemental Security Income (SSI), Retirement, Survivors and Disability Insurance (RSDI) benefits, or Veterans Benefits for the Elderly is reissued because an individual representative payee misuses benefits, the reissuance is excluded as a resource for nine months if retained after the month of receipt.
Retroactive RSDI and SSI benefits are excluded for the nine (9) calendar months following the month in which the person receives the benefits. Any accrued interest on that account is counted as income in the month received and as a resource in the following months.
State Annuities for Certain Veterans
Relocation payments, State and local
Tax credits, rebates, and refunds are excluded for 12 months after the month of receipt

Federally Mandated Resource Exclusions
Term life insurance

Chapter 40 - Medicaid for Elders and Adults with Disabilities

Subchapter 05 - Community Medicaid

Medicaid for Elders and Adults with Disabilities: Community Medicaid (210-RICR-40-05-1)

1.1 Overview

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

1.2 Authority

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

1.3 Scope and Purpose

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

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

1.4 Definitions

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

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

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

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

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

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

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

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

1.5 Eligibility for Elders and Adults with Disabilities

1.5.1 Scope and Purpose

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

1.5.2 EAD Eligibility Pathway - Low-income Elders and Adults with Disabilities

A. Under the Social Security Act, 42 U.S.C. § 1396(a) states have the option under the Medicaid State Plan of expanding eligibility to elders and adults with disabilities up to and inclusive of one- hundred percent (100%) of the FPL. Rhode Island chose this option in 1999 and now refers to this categorically eligible expansion group by the acronym “EAD.” The EAD coverage group has higher income and resource limits than the SSI program and serves, therefore, as the State’s chief general eligibility pathway for anyone with an SSI characteristic who does not qualify for SSI benefits. Coverage group features are as follows:

1. Eligibility Criteria - To qualify for Medicaid coverage through the EAD eligibility pathway, a person must meet the general eligibility requirements related to residency, citizenship and cooperation set forth in § 1.9 of this Part and the following:

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

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

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

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

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

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

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

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

3. Continuing Eligibility -- With implementation of the State's IES, EOHHS is instituting a modified passive renewal process. Beneficiaries are required to review and update a pre- populated form containing information obtained in their accounts and updated monthly or quarterly through electronic data matches about eligibility factors subject to change. Detailed provisions pertaining to the passive renewal process are set forth in § 00-2.7.2(A)(5) of this Chapter.

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

1.5.3 Medically Needy (MN) Eligibility Pathway

Medically needy eligibility is available to certain IHCC group members who do not need LTSS. (Different rules apply for LTSS eligibility as indicated in the Medicaid Code of Administrative Rules, Flexible Test of Income). Under the RI Medicaid State Plan, MN coverage is an option for elders and adults with disabilities, parents/caretakers, children and pregnant women. Adults 19-64 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 § 1.7.3. of this Part. See Subchapter 5 Part 2 of this Chapter for provisions related to the Community Medicaid MN pathway.

1.5.4 SSI and SSP Recipients and SSI Protected Status

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

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

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

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

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

Security Income (SSI) and State Supplemental Payment Program and are available on the RI Secretary of State's website at: http://sos.ri.gov/.

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

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

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

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

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

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

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

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

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

c. Continuing eligibility. Persons eligible under the Pickle Amendment are subject to EAD passive renewal requirements. The COLA disregards continue to apply as long as income permits. As the SSI benefit rises from year to year, it may increase to an amount that exceeds the RSDI and the countable income amount at the time SSI eligibility ceased. At this point, the State discontinues Pickle Amendment eligibility and determines whether eligibility through an alternative pathway is available.

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

e. Applicant/beneficiary responsibilities. Potential members of this coverage group must provide any additional information that may be required to determine eligibility and comply with the applicable general requirements for SSI-based eligibility set forth in § 1.9 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/news/cola/automatic-cola.htm

4. Employed Persons with Disabilities, 42 U.S.C. § 1619(a)

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

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

(1) Maintain disability status while working;

(2) Meet all other SSI eligibility criteria;

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

b. Determination process. As long as the beneficiary meets the criteria for 42 U.S.C. § 1619(a), no income or resource standards apply e.g., income can be above the EAD limits set forth in § 1.5.2 of this Part.

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

d. Agency responsibilities. The SSA determines initial and continuing eligibility and notifies the EOHHS on a monthly basis of beneficiaries who qualify for 42 U.S.C. § 1619(a) coverage. The EOHHS is responsible for determining whether beneficiaries who no longer qualify are eligible through an alternative eligibility pathway.

5. Medicaid While Working, 42 U.S.C. § 1619(b) of the Social Security Act, provides Medicaid to employed persons with disabilities who no longer qualify for 42 U.S.C. § 1619(a), but need coverage to continue working. This pathway preserves Medicaid eligibility when a working person's total countable income, both earned and unearned, including deemed income, is too high for an SSI cash payment. Unlike 42 U.S.C. § 1619(a) coverage, 42 U.S.C. § 1619(b) provides "Medicaid While Working" protection when SSI cash benefits are no longer available. Medicaid health coverage is preserved for both members of a couple under 42 U.S.C. § 1619(b) if each is working, and their total combined income would result in the loss of SSI cash benefits, even if the income of one would not alone trigger non-payment status. However, a non-working spouse has no protection under 42 U.S.C. § 1619(b) and loses Medicaid when the earned income of his or her spouse exceeds the limits for SSI cash benefits. For Community Medicaid health coverage through this pathway, the following apply:

a. Eligibility Criteria. A person must have received an SSI cash payment based on disability, including under 42 U.S.C. § 1619(a), for at least one month in the most recent SSI benefit period, and -

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

(2) Have insufficient earnings to replace the SSI/SSP cash benefit, Medicaid health coverage, and/or personal care or attendant

services that would be available if they did not have such earnings; and

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

b. Determination process. As long as the beneficiary meets the eligibility criteria for Medicaid While Working, and income remains below the 42 U.S.C. § 1619(b) threshold for Rhode Island, which changes annually and can be obtained on the Social Security Administration's website, no income or resource standards apply.

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

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

6. Protected Surviving Spouses - In the Omnibus Budget Reconciliation Act of 1990 (OBRA '90, 1990 U.S.C.C.A.N. 2374). Congress permanently revised eligibility standards set in § 1634(b) of the Social Security Act to protect access to Medicaid health coverage for divorced and surviving spouses who lose SSI eligibility as a result of RSDI benefits.

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

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

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

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

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

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

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

7. Adult Dependent Child with Disabilities -42 U.S.C. § 1634 of the Social Security Act provides protection of Medicaid eligibility status for certain adult children with disabilities who lose SSI due to income from a parent's RSDI benefits or Social Security Disability (SSD) benefits from the adult child's own work record. For the purposes of this coverage, "adult child" includes an adopted child, or, in some cases, a stepchild, grandchild, or step grandchild who is unmarried and is age 18 or older. When determining EAD eligibility for members of this group, the parent's RSDI or child's SSD benefit is disregarded to preserve continuing Medicaid eligibility.

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

(1) At least 18 years of age;

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

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

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

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

c. Continuing eligibility. Protected status as a result of the RSDI or SSD disregard continues to apply as long as the beneficiary meets the

disability/blindness criteria, there are no additional sources of increased countable income, and resources remain within the applicable limits.

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

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

9. State Supplemental Recipients, 12/73 - This coverage group consists of Medicaid beneficiaries eligible under the Medicaid State Plan on the basis of SSI in December 1973 and their spouses who continue to live with them and are essential to their well-being. Medicaid eligibility of the spouse continues as long as the SSI recipient remains eligible under the 1973 eligibility requirements. The SSA notifies the State of persons who are deemed eligible in this group.

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

1.6 The Medicare Premium Payment Program (MPPP)

1.6.1 SCOPE AND PURPOSE

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

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

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

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

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

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

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

b. Medicare Part B. Pays for physician services, durable medical equipment and other outpatient services. Medicare Part B is available to persons who pay a monthly premium and are 65 years of age or older without regard to whether they are insured in the Social Security or Railroad Retirement Systems as well anyone who has reached the 25th month of a permanent and total disability. Initial enrollment is a seven-month period that starts three (3) months before a person first qualifies for Medicare and extends three months past the 65th birthday or, if failing to enroll during this period, through an open enrollment period held each year from January through the end of March. The State pays the Part B premium for Medicare beneficiaries eligible through all of the MPPP eligibility pathways listed below.

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

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

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

1.6.2 MPPP Eligibility Pathways

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

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

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

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

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

d. Deeming rules do not apply.

e. There is no retroactive coverage.

2. QMBs with Medicaid health coverage (QMB Plus) - Persons who qualify through this pathway must be entitled to Medicare Part A, have countable income at or below 100% of the FPL, and resources at $4,000 individual or $6,000 couple. Beneficiaries eligible through this pathway are full dual eligible beneficiaries and receive premium assistance and Medicaid health coverage. Includes MN Medicaid beneficiaries. Access to Medicaid retroactive coverage, continuing eligibility, and the full scope of Medicaid essential benefits is available.

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

a. Medicaid pays the Medicare Part B premium to SSA

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

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

d. Deeming rules do not apply.

e. Retroactive coverage may be available.

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

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

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

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

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

7. Qualifying Individuals-1 (QI-1) - To qualify for eligibility through this pathway, beneficiaries must be entitled to Medicare Part A, have countable income of at least 120% FPL, but less than 135% FPL, resources that do not

exceed the amounts set by the federal government (see § 1.6 of this Part), and be otherwise ineligible for Medicaid. Medicaid pays Medicare Part B premiums only. Federal matching funds for members of this group is 100 percent and, as such, the availability of financial assistance through QI-1 eligibility is contingent on federal appropriations. For members of this group:

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

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

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

d. Deeming applies.

e. Retroactive coverage is available.

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

1.6.3 MPPP Application Process

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

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

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

1.6.4 MPPP Eligibility and Continuing Eligibility

Persons seeking MPPP assistance are subject to the SSI-methodology for determining financial eligibility, though the income and resources standards specific to the MPPP coverage group, as indicated in § 1.6 of this Part, are applied. A disability determination is not required for MPPP financial help only. With the implementation of the State's IES, continuing eligibility is determined using a modified passive renewal process (See § 00-2.7.2(A)(5) of this Chapter).

1.6.5 MPPP Summary

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

MPPP Eligibility Pathways - 2018			
Coverage Group	**Full or Partial Eligible**	**Income and Resource Limits** **Individual/Couple**	**Benefits**
QMB	Partial Dual	100% FPL All MPPP applicants receive a $20 income disregard. $7,560 - Individual $11,340 - Couple	Entitled to Medicare Part A and qualify for Medicaid payment of: Medicare Part A premiums (if needed) Medicare Part B premiums Certain premiums charged by Medicare Advantage plans Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program)
QMB +	Full Dual	100% FPL $4,000 / $6,000	All of the above AND Medicaid health coverage
SLMB	Partial Dual	101-125% FPL $ $7,560 - Individual $11,340 - Couple	Entitled to Medicare Part A and qualify for Medicaid payment of: Medicare Part B premiums

MPPP Eligibility Pathways - 2018			
Coverage Group	**Full or Partial Eligible**	**Income and Resource Limits** **Individual/Couple**	**Benefits**
SLMB +	Full Dual	101-120% FPL $4,000 / $6,000	Same as above AND: Certain premiums charged by Medicare Advantage plans Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program) Full Medicaid Coverage
QI	Partial Dual	121-135% FPL $7,560 - Individual $11,340 - Couple	Entitled to Medicare Part A and qualify for Medicaid payment of: Medicare Part B premiums
QWDI	Partial Dual	$4,000 - Individual $6,000 - 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

1.7 Special Coverage Groups

1.7.1 Overview

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

1.7.2 Breast and Cervical Cancer

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

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

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

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

a. Attains age sixty-five (65);

b. Acquires qualified health insurance/creditable coverage;

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

d. Fails to complete a scheduled redetermination;

e. Is no longer a RI resident; OR

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

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

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

1.7.3 Refugee Medical Assistance (RMA) - MN Option

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

1. Eligibility Criteria - Any member of the federal resettlement program for refugees who has income at or below 200 percent of the FPL and is otherwise ineligible for Medicaid or an HSRI plan providing financial help, may apply for RMA using the MN process. This included adults 19 to 64 who have no other Medicaid MN eligibility option and certain persons in need of LTSS. The criteria set forth in § 1.11.6 of this Part for Community Medicaid apply for establishing the spenddown period and allowable expenses except there are no resource requirements and deeming is not permitted.

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

3. Continuing Eligibility - Receipt of RMA under the characteristic of "refugee" is limited to the first eight (8) months residing in the United States, beginning with the month the refugee initially entered the United States, or the entrant was issued documentation of eligible status by the federal government.

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

b. No Five Year Bar. Federal law exempts refugees from the five (5) year bar for qualified non-citizens established under the U.S. Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, U.S.C 1305 § 401. Once the (8) eight-month RMA period ends, states are required to continue Medicaid eligibility under any other coverage group for which a refugee may qualify providing all other requirements are met. (See Medicaid Code of Administrative Rules, Evaluation of Resources, for more immigration information.) Renewals for continuing coverage are conducted in accordance with the applicable coverage group requirements including six month budget periods through the MN pathway.

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

5. Applicant/beneficiary responsibilities - Beneficiaries are responsible for meeting the spenddown requirements set forth in Part 2 of this Subchapter.

1.7.4 Sherlock Plan

The Sherlock Plan Medicaid for Working People with Disabilities Program is an SSI-related IHCC group comprised of working adults with disabilities pursuant to the Balanced Budget Act of 1997, 42 U.S.C. § 1396a(a)(10)(ii)(XIII). Eligibility for the Sherlock Plan is included in Medicaid Code of Administrative Rules, Sherlock Program, which focuses on Medicaid eligibility for adults with disabilities who are working.

1.7.5 Emergency Medicaid

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

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

a. Persons under age 65. All persons in this group are evaluated for the MACC groups identified in Medicaid Code of Administrative Rules, Overview of Affordable Care Coverage Groups, using the MAGI, at the income limit applicable for the population to which they belong - e.g., child, adult or parent/caretaker, pregnant woman. There is no resource limit and no determination of disability.

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

c. Medically Needy. Persons who are ineligible under §§ 1.7.5(1)(a) or (b) of this Part because their income is too high, may seek coverage through the IHCC pathway as MN in accordance with § 1.5.3 of this Part and Part 2 of this Subchapter in detail.

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

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

2. Determination Process - Emergency service providers - typically an acute care facility such as a hospital - provide assistance with completing any required forms upon determining, in conjunction with the presumptive eligibility process specified in Medicaid Code of Administrative Rules, Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals, that emergency Medicaid coverage may be required. In situations in which eligibility for emergency Medicaid cannot be determined or ascertained in this process, an agency eligibility specialist is contacted to provide the non-citizen with assistance in applying for coverage and assuring payment is made for any of the Medicaid-covered emergency services rendered. MN eligibility is available, as a last resort, for non-citizens who have income above the applicable eligibility limits for other

coverage groups if the costs incurred for emergency services are sufficient for a spenddown. Payments to providers are typically made post-treatment.

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

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

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

1.8 Community Medicaid -- LTSS Preventive Services

1.8.1 Authority

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

1.8.2 Scope of Services

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

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

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

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

1.8.3 Clinical Review

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

1.8.4 Limits

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

1.8.5 Continuing Need

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

1.9 Community Medicaid General Eligibility Requirements

1.9.1 Scope and Purpose

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

1.9.2 Characteristic Requirements

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

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

a. Verification: An applicant’s age is verified electronically with information about date of birth from the SSA and/or the RI Department of

Health, Division of Vital Statistics. If data matches are unsuccessful, an applicant is required to provide paper documentation of date of birth to support a self-attestation of age.

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

1.9.3 Non-Financial Criteria

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

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

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

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

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

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

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

be granted Rhode Island Medicaid even though they continue to receive a state supplemental payment from another state.

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

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

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

(AA) The parents or legal guardian, if one has been appointed, or

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

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

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

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

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

(BB) While incapable of stating intent; or

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

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

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

or she owns a home in another state and has an intent to return there even if the likelihood of return is apparently nil.

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

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

(1) Obtaining necessary health care;

(2) Visiting;

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Living in own home such as a house, apartment, or mobile home or someone else's household. Affects Medicaid MACC household composition and RIte Share participation and thus is a factor considered in the process noted in § 1.9.3(2) of this Part.

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

(3) Residing in a health care or treatment institution such as a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities, residential care facility for adults or children requiring treatment or rehabilitation services. An institution is, for these purposes, an establishment that furnishes food, shelter and some health treatment, services, and/or supports

to four (4) or more persons unrelated to the proprietor. Determines Medicaid eligibility group size and countable income;

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

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

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

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

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

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

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

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

d. Correctional Facility. While living in a correctional facility, including a juvenile facility, Medicaid health coverage for otherwise IHCC eligible

persons is suspended except for in-patient and emergency services provided outside of the facility. Residence in a correctional facility begins on the date of incarceration and continues until the date the person is released from the correctional facility. A person transferred from a correctional facility to a hospital for part or all of the sentencing period is considered to be still living in the correctional facility for general eligibility purposes, unless the exemption for Medicaid coverage of in-patient and emergency care applies.

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

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

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

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

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

b. Non-qualified Non-citizen. With the exception of pregnant women, adult "non-qualified" non-citizens are not eligible for Medicaid. Non-qualified non-citizens are persons from other nations who are not considered to be immigrants under current federal law, including those in

the United States on a time-limited visa (such as visitors or person in the U.S. on official business) and those who are present in the country without proper documentation (includes people with no or expired status). Non-qualified non-citizens may obtain Medicaid health coverage in emergency situations only, as indicated in § 1.7.5 of this Part. Non-emergency services may be obtained through Federally Qualified Community Health Centers.

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

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

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

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

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

c. Agree to apply for eligibility for any other forms of public assistance which may be available upon receiving notification from the EOHHS in accordance with the Medicaid Code of Administrative Rules, Resources Generally;

d. Enroll in a RIte Share-approved employer-sponsored health insurance plan if cost-effective to do so, in accordance with the Medicaid Code of Administrative Rules, RIte Share Program; and

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

1.9.4 Good Cause for Failing to Cooperate

A. A Medicaid applicant or beneficiary must have the opportunity to claim good cause for refusing to cooperate. Good cause may be claimed by contacting an agency representative. To claim good cause, a person must state the basis of the claim in writing

and present corroborative evidence within twenty (20) days of the claim; provide sufficient information to enable the investigation of the existence of the circumstance that is alleged as the cause for non-cooperation; or, provide sworn statements from other persons supporting the claim.

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

2. The determination as to whether good cause exists must be made within thirty (30) days of the date the claim was made unless the agency needs additional time because the information required to verify the claim cannot be obtained within the time standard. The person making the claim must be notified accordingly.

B. Upon making a final determination, notice must be sent to person making the claim. The notice must include the right to appeal through the EOHHS Administrative Fair Hearing Process set forth in the Medicaid Code of Administrative Rules, Complaints and Appeals, or its successor regulation.

1.10 State-Administered Community Medicaid Disability Determinations

1.10.1 Scope and Purpose

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

1.10.2 Disability Standards for Community Medicaid

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

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

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

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

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

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

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

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

1.10.3 MART Five Step Determination Process

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

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

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

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

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

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

1.10.4 Referral to the MART

A. All adults over age nineteen (19) applying for Medicaid are evaluated by the Integrated Eligibility System using the MAGI standard before consideration using the SSI-methodology. The application includes questions about a person's need for care,

previous or pending disability determinations and the need for retroactive Medicaid, which provides coverage for certain health expenses incurred in the three (3) months prior to making application.

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

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

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

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

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

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

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

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

1.10.5 Continuing Eligibility for EAD Adults with Disabilities

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

1. Medicaid Renewal -- Beneficiaries eligible through the EAD pathway on the basis of a disabling impairment are renewed on an annual basis in accordance

with the provisions of § 00-2.7 of this Chapter, subject to periodic reviews by the MART.

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

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

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

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

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

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

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

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

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

5. The eligibility of Medicaid beneficiaries who are 65 and older are renewed on an annual basis in accordance with the provisions located in Subchapter 00 Part 2 of this Chapter.

1.10.6 Agency and Applicant Responsibilities

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

1.11 Financial Eligibility Determination

1.11.1 Scope and Purpose

To determine a person's eligibility using the SSI methodology, a comparison is made between the countable income and resources of the applicant's FRU and the income limits applicable to the Medicaid eligibility IHCC group. Once these groups have been established, financial eligibility is determined in accordance with the provisions for the SSI treatment of income and resources set forth in §§ 00-3.1 through 00-3.5 of this Chapter, and/or the special eligibility requirements in § 1.7 of this Part. This section focuses on the financial eligibility determination process for the Community Medicaid pathways in which the State is responsible for initial and continuing eligibility.

1.11.2 The Medicaid Eligibility Group

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

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

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

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

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

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

(3) When the resources of the couple are reassessed and allocated at the point in which the need for continuous LTSS is determined and an application for Medicaid coverage of LTSS is made as indicated in the Medicaid Code of Administrative Rules, Evaluation of Resources, and Resource Transfers.

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

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

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

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

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

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

1.11.3 Formation of the FRU

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

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

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

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

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

2. FRU for Sponsored Non-citizens - The FRU for a non-citizen admitted to the United States on or after August 22, 1996 based on a sponsorship under the Immigration and Nationality Act (INA), 8 C.F.R. § 204 includes the income and resources of the sponsor and the sponsor's spouse, if the spouse is living with the sponsor, when all four of the following conditions are met:

a. The sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to conform to the requirements of 8 C.F.R. § 213A(b);

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

c. The non-citizen is not battered; and

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

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

1.11.4 General Rules for Counting Income - Community Medicaid

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

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

a. Federal law. Exclusions mandated in federal law or regulations as set forth in § 00-3.4 of this Chapter are applied first unless indicated otherwise.

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

(1) Any refund of taxes;

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

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

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

(BB) Any portion of such educational assistance that is not used to pay current tuition, fees or other necessary educational expenses but is set aside to be used for paying this type of educational expense at a future date is excluded from income in the month of receipt. If these funds are not spent after nine (9) months, they become a countable resource the first day of the tenth month following receipt.

(CC) Any portion of a grant, scholarship, fellowship, or gift that is not used or set aside for paying tuition, fees, or other necessary educational expenses is income in the month received and a resource the month after the month of receipt if retained.

(4) Food which a person or his/her spouse raises if it is consumed by the household;

(5) Assistance received under the Disaster Relief and Energy Assistance Act (as in effect on February 1, 2016) and assistance provided under any federal statute because of a presidentially declared disaster;

(6) The first sixty dollars of infrequent or irregular unearned income received in a calendar quarter;

(7) Alaska longevity bonus payments;

(8) Foster care payments that are not funded through Section IV-E;

(9) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become a part of that burial fund;

(10) Support and maintenance assistance based on need:

(AA) Provided in-kind by a private nonprofit agency; or

(BB) Provided in cash or in-kind by a supplier of home heating oil or gas, or by a private or municipal utility company.

(11) One-third of child support payments made by a non-custodial absent parent, unless exempt in accordance with § 00-3.3 of this Chapter;

(12) Twenty dollar ($20.00) general income disregard. The disregard does not apply to program payments when income is used as an eligibility factor and the payment is wholly or partially

funded by the federal government or by a non-governmental agency such as Catholic Charities or the Salvation Army.

(13) Unearned income used to fulfill an approved plan to achieve self-support (PASS);

(14) Federal housing assistance provided by:

(AA) An office or program of the U.S. Department of Housing and Urban Development (HUD); or

(BB) The U.S. Department of Agriculture's Rural Housing Service (RHS), formally known as the Farmers Home Administration (FHA);

(15) Any interest on excluded burial space purchase agreement if left to accumulate as part of the value of the agreement;

(16) The value of any commercial transportation ticket which is received as a gift and is not converted to cash;

(17) Payments from a State compensation fund for victims of crime;

(18) Relocation assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 in accordance with 42 U.S.C.§ 301 (as in effect on February 1, 2016) provided to individuals displaced by any federal or federally-assisted project or state or local government or through a state-assisted or locally-assisted project involving the acquisition of real property;

(19) Combat fire pay received from the uniformed services;

(20) Interest on a dedicated account in a financial institution, the sole purpose of which is to receive and maintain past-due SSI benefits which are required or allowed to be paid into such an account, and the use of which is restricted by 42 U.S.C. § 1631(a)(2)(F);

(21) Gifts to children with life-threatening conditions from an organization described in § 501(c)(3) of the Internal Revenue Code of 1986 (as in effect on February 1, 2016), within the following limitations:

(22) In-kind gifts are not converted to cash;

(23) No more than the first two thousand dollars of any cash gifts within a calendar year may be excluded;

(24) Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than 42 U.S.C. § 1613(a) (as in effect on February 1, 2016);

(25) An annuity paid by a state, to a person and/or the person's spouse, on the basis of the state's determination that the person is a veteran and is blind 65 or older and/or living with a disabling impairment.

2. Order of Earned Income Exclusions -- In general, earned income disregards and exclusions are applied in the following order -

a. Federal law. Exclusions mandated in federal law or regulations as set forth in § 00-3.4 of this Chapter are applied first, unless indicated otherwise.

b. SSI Methodology. The following types of earned income are excluded or disregarded in order:

(1) Earned income tax credit payments and child care tax credit payments;

(2) The first $30 of infrequent or irregular earned income received in a calendar quarter;

(3) Student earned income exclusion (SEIE) up to the monthly limit, and not more than the yearly limit as indicated in § 00-3.1.7 of this Chapter.

(4) Any portion of the $20 monthly general income disregard which has not been excluded from unearned income in that same month;

(5) The first $65 of earned income in a month;

(6) Earned income of a person with disabilities used to pay impairment-related work expenses (IRWEs), as described in 20 C.F.R. § 404.1576;

(7) One-half of remaining earned income in a month;

(8) Work expenses of a person who is blind;

(9) Earned income used to fulfill an approved plan to achieve self-support (PASS).

3. Unused exclusions and disregards -When calculating countable income, the limitations below apply:

a. Exclusions never reduce earned or unearned income below zero.

b. Unused portions of a monthly disregard or exclusion cannot be carried over for use in subsequent months.

c. Unused earned income disregards and exclusions are never applied to unearned income.

d. Other than the $20 general income disregard, no unused unearned income exclusion may be applied to earned income.

e. The $20 general and $65 earned income exclusions are applied only once to a couple, even when both members have income, since the couple's earned income is combined in determining Medicaid eligibility.

1.11.5 Income Deeming

A. To deem income is to attribute one person's countable income in the calculation of another person's countable income. Income deeming requirements are based on the FRU rather than the Medicaid eligibility group rule. A person may be included in the Medicaid eligibility group without being included in the FRU - (e.g., the sibling of a child seeking MN eligibility -) and having their income deemed to an applicant or non-applicant in the household. The general rules for determining countable income related to the application of earned and unearned income exclusions identified above in § 1.11.4 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 income is deemed to an applicant is determined separately for each member of the FRU.

3. Income based on need, in which income is a factor in determining eligibility, provided by any local, state or federal agency and any income which was taken into account in determining eligibility and which affected the amount of such assistance or payment is excluded in the income deeming process, unless specifically indicated otherwise. Includes: SSI; SSP; RI Works and GPA cash assistance; Veteran's Administration (VA) pensions; or in-kind support and maintenance.

B. Spouse-to-Spouse --Except as indicated in the situations noted below, the income of a NAPP spouse is deemed to an applicant if the spouses live together. If an applicant is not divorced but is legally separated from his or her spouse, and continues to live in the same

household, the NAPP spouse's income is deemed. In the following situations, spouse-to-spouse income deeming does not apply:

1. The spouses do not live together.

2. The applicant is seeking coverage under the Sherlock Plan as a working adult with a disability in accordance with the Medicaid Code of Administrative Rules, Sherlock Plan.

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

(1) An amount equal to the deeming standard for each dependent child in the household. The "deeming standard" is the difference between the Federal Benefit Rate (FBR) for a couple and the limit for a single person, as indicated in § 00-3.1.7 of this Chapter, less any countable income from that the child. The difference between is the living allowance for the NAPP child, as indicated herein.

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

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

(4) If the NAPP spouse's remaining income after exclusions and disregards are applied is greater than the deeming standard, then the couple's income is calculated according to the general rules for determining countable income using SSI methodology. That income is then compared against the Medicaid eligibility group income limit for the family size involved - i.e., household size.

b. Treatment of deemed income. The deemed amount is counted as unearned income in determining the applicant's income eligibility for Medicaid.

C. Parent-to-Child -- Except in the situations noted below for MN eligibility, the income of a biological or adoptive parent is deemed to a child who is under age 18 and living with a parent as long as the child has not been legally emancipated. When the father is not married to the child's mother, the father's income is only deemed to the child if they reside together and paternity has been established.

1. In the following situations, the income of a parent is NOT deemed to a child:

a. The child is not eligible for SSI, but is participating in a foster care or adoption subsidy program administered by the State.

b. The child is seeking LTSS through the Katie Beckett eligibility option in accordance with the Medicaid Code of Administrative Rules, Global Consumer Choice Waiver.

2. Deeming Rules: The amount of income deemed from parent to child requires a multi-step calculation of income that must be followed in the sequence below:

a. The earned and unearned income of the parents of the applicant child is calculated allowing the standard exclusions EXCEPT for the standard $20 and $65 plus one-half disregards.

b. The living allowance allocated to NAPP children is determined by multiplying their number by the deeming standard. Any children receiving SSI or RI Works cash assistance are not included in this calculation. The income of each NAPP child is deducted from this sum, if any.

c. The total of the unearned income of the parents is calculated and then any remaining allowance for NAPP children in the household not met by their own income is subtracted.

d. The earned income of the parents is totaled and any remaining living allowance for NAPP children is subtracted. If there is no remainder, there is no income to deem. If there is income remaining, deeming is applicable.

e. Deemed income from parent to child is then calculated by: deducting the $20 income disregard from any remaining parental unearned income; subtracting $65, plus any of the remainder of the $20 disregard and one-half of the still remaining parental earned income. The remaining unearned and earned income is added and, from this total, so too is the individual FBR (for a one (1)-parent household) or the couple FBR (for a two (2)-parent household).

f. The remaining income is deemed to be unearned income to the child. Note: If more than one child is applying, deemed income is divided equally.

D. Other Household Members -- When determining a person's initial or continuing eligibility, income is NOT deemed from a:

1. Child to a parent;

2. Sibling to another sibling, or other children under 21 living in the household;

3. Stepparent to a stepchild;

4. Grandparent to a grandchild; or

5. Relative caretaker to a child.

E. Sponsor Deeming -- Sponsor deeming rules apply to non-citizens who are sponsored by one or more individuals under a signed Affidavit of Support (USCIS I-1864), unless one of the following exceptions applies.

1. Exceptions to Sponsor Deeming. Sponsor deeming does not apply to sponsored non-citizens when:

a. The non-citizen is under age 21.

b. The non-citizen is pregnant. This exception ends when the sponsored pregnant woman's 60-day postpartum period ends. Sponsor deeming applies the month following the end of the postpartum period.

c. The non-citizen has sponsorship deferred by USCIS when their immigration status is changed to "Battered Non-citizen."

d. If the non-citizen needs placement in a facility and placement is jeopardized by the sponsor's failure or inability to provide support, or inability of the non-citizen to locate the sponsor.

2. General rules of sponsor deeming. Income of a sponsor and the sponsor's spouse is deemed to each non-citizen covered by the affidavit regardless of whether the sponsor actually contributes to the non-citizen's support and maintenance needs. Income is deemed even if the sponsor or the sponsor's spouse is receiving public assistance in Rhode Island or another state. The following types of income of the sponsoring individual/couple are deemed:

a. Gross income, including any cash assistance received by the sponsor or the sponsor's spouse;

b. Net self-employment income, minus self-employment expenses;

c. If the sponsor is a member of the FRU, the sponsor's income is already deemed to the sponsored non-citizen spouse and family members in accordance with income deeming rules contained in § 1.11.5(E) of this Part.

3. If the sponsor is not a member of the FRU or is a member of the Medicaid eligibility group whose income is not deemed under income deeming rules § 1.11.5(E) of this Part, the following apply:

a. The total gross income of the sponsor and the sponsor's spouse is deemed to each sponsored non-citizen.

b. The sponsor or the sponsor's spouse's income are considered available and are not excluded.

1.11.6 General Rules for Counting Resources - Community Medicaid

A. The State uses a more simplified process for counting resources for Community Medicaid, as explained in § 00-3.5.1 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.

1. Process - The process rules identified in § 00-3.6.2 of this Chapter are used in evaluating resources to determine which are included in the calculation.

2. Application of Exclusions - Both federally mandated and program specific exclusions are applied for resources of a Community Medicaid applicant or beneficiary, the following items are excluded in the following order in the amounts indicated:

a. The home and adjoining land;

b. Household goods and personal effects;

c. One automobile and the equity value of a second vehicle above $4,500;

d. Property of a trade or business which is essential to the means of self-support;

e. Non-business property which is essential to the means of self-support;

f. Resources of person who is blind or living with a disabling impairment which are necessary to fulfill an approved PASS;

g. Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act;

h. Whole life insurance owned by a person and/or spouse but only when the combined face value of all policies per person is at or below $1,500 for EAD or $4000 for medically needy;

i. Restricted allotted Indian lands;

j. Payments or benefits provided under a federal statute other than Title XVI (OASDI, including RSDI and SSD) of the Social Security Act where an exclusion is required by such statute as indicated in § 00-3.6 of this Chapter;

k. Disaster relief assistance;

l. Burial expense funds and set asides to the extent allowed up to $1,500 for EAD and $4,000 for persons who are MN;

m. Title XVI (OASDI) or Title II (SSI) retroactive payments;

n. Housing assistance;

o. Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit;

p. Payments received as compensation for expenses incurred or losses suffered as a result of a crime;

q. Relocation assistance from the State or a local government;

r. Dedicated financial institution accounts;

s. Gifts to children under age 18 with life-threatening conditions;

t. Restitution of SSI, title VIII or RSDI benefits because of misuse by certain representative payees;

u. Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses;

v. Payment of a refundable child tax credit, as provided; and

w. Any annuity paid by a state to a person (or his or her spouse) based on the State's determination that the person is a veteran (as defined in 38 U.S.C. § 101) and blind, living with a disabling impairment, or aged.

1.11.7 Resource Deeming

A. To deem resources is to count one person’s resources in the calculation of another person’s countable resources. As with income deeming, resource deeming requirements apply to members of the FRU, which is not always the same as the Medicaid eligibility group. Only the resources of the applicant's spouse or the parent(s) of a child are considered for the purposes of deeming resources. The deeming process proceeds as follows:

1. Spouse- to-Spouse - In deeming resources from one spouse to the other, only the resources of the couple are considered.

a. Living together. When an applicant and NAPP spouse live together, all resources are combined and the couple is permitted resources up to the amount allowed for the Medicaid eligibility group of two. The couple's resource limitation is not affected by whether the spouse of the applicant is applying for or receiving Medicaid or is a non-applicant.

b. Living apart. When an applicant and spouse are no longer living together, each person is considered as an individual living alone beginning the month after separation and the individual resource limit applies. For the month of separation, the spouses are treated as couple, as long as they were living together at some point during the month.

2. Single individual -When an applicant is not living in a home with a spouse or parent(s), only the resources of the applicant are considered. The resource limits for an "individual" or Medicaid eligibility group of one apply.

3. Parent-to-child - In deeming resources from a parent to a child, the resources of a child consist of whatever resources the child has in his or her own right plus whatever resources are deemed to the child from his or her parent(s).

a. In determining the amount of resources to be deemed to an applicant child, the resources of the child and of the parents are computed separately and both the child and the parents are each allowed all of the resource exclusions they would normally be eligible to receive in their own right. Only one home and one vehicle are completely excluded, however. The equity value of a second vehicle is counted in accordance with § 00-3.5.5(A)(1)(d) of this Chapter.

b. It does not matter whether a parent(s) is or is not eligible for Medicaid.

c. After the exclusions are applied, only the countable resources over the resource exclusion of the parent(s) living in the home are deemed to the child when there is only one child.

d. When there is more than one applicant/eligible child, the resources available for deeming are shared equally among the eligible children.

e. None of the parents' resources are deemed to any other non-applicant/ineligible children.

f. A child is not eligible for Medicaid as MN if his or her own countable resources plus the value of the parents' resources deemed to the child exceed the resource limit for an individual- Medicaid Eligibility group of one - of $4,000.

Chapter 40 - Medicaid for Elders and Adults with Disabilities

Subchapter 05 - Community Medicaid

Community Medicaid: Medically Needy Eligibility (210-RICR-40-05-2)

2.1 Scope and Purposes

A. A medically needy (MN) spenddown, previously referred to as the "Flexible Test of Income", is a cost-sharing approach that provides a Medicaid eligibility pathway for certain people who have income above the limit for their applicable coverage group if they have high health expenses. Under the State's Medicaid State Plan, members of these populations become eligible for Medicaid by "spending down" their income to a limit established by the state - - known as the medically needy income limit or "MNIL" by deducting certain health care expenses. The following populations may be medically needy eligible under this section:

1. Elders and adults with disabilities with income above 100 percent of the FPL;

2. Children with income above the MACC limit of 266% of the FPL (includes the 5% disregard);

3. Pregnant women with income above the MACC limit of 258% of the FPL (includes the 5% disregard);

4. Parents/caretakers with income above the MACC limit of 138% of the FPL (includes the 5% disregard);

5. Non-qualified non-citizens seeking coverage for emergency Medicaid if ineligible under all other pathways. (See § 1.7.5 of this Subchapter); and

6. Certain refugees, as defined in § 1.7.3 of this Subchapter, who do not otherwise qualify for Medicaid health coverage or commercial insurance with financial help through HSRI.

B. This section describes the Community Medicaid (non-LTSS) MN eligibility pathway in general and establishes the provisions governing initial and continuing eligibility for persons in these populations seeking Medicaid health coverage through this option.

2.2 General Provisions Eligibility Criteria

A. For the IHCC groups in this section, MN coverage is available to elders and persons with disabilities with high medical expenses who have income above the EAD income limit, but otherwise meet all of the general eligibility requirements for Medicaid set forth in § 1.9 of this Subchapter.

1. Determination process – Applicants who do not meet the income limits for Medicaid in the IHCC groups are automatically evaluated for MN coverage. Members of the MACC groups must contact an agency eligibility specialist if seeking MN coverage. The MN cases are determined for a six (6) month period beginning with the first day of the month in which the application is received. Eligibility for Medicaid health coverage as MN is not established, however, until the applicant has presented proof of health expenses incurred and paid or that remain outstanding for the eligibility period. Any health expenses for which a beneficiary continues to be liable dating back to the retroactive period are also considered.

2. Continuing eligibility – The date of eligibility is the actual day of the month the applicant incurs a health expense – not the billing date – which reduces income to the MNIL. Eligibility may be renewed on a continuing basis if the beneficiary is liable for health care expenses that exceed current income. Otherwise, a re-evaluation of eligibility, based on the cost of health costs currently being incurred is required.

3. Agency responsibilities – The EOHHS must inform applicants who have income above the applicable limit for the appropriate IHCC group that MN coverage is an option and provide information about allowable health expenses for spenddown purposes and the scope and limits of obtaining coverage through this eligibility pathway. In addition, applicants must be informed of the impact of obtaining MN Medicaid health coverage for other programs, including the Supplemental Nutrition Assistance Program (SNAP) and the MPPP.

4. Applicant/beneficiary responsibilities – Eligibility and renewal is contingent upon the applicant/beneficiary providing bills and receipts related to allowable health care expenses that are not paid through a third party. Therefore, the chief responsibility of the applicant/beneficiary is to maintain and present this information, unless submitted directly by a provider, to the state agency.

2.3 Spenddown Calculation

A. For a person who has income above the income standard across applicable eligibility pathways, the spenddown standard for their eligibility coverage group is applied. For example, the appropriate spenddown standard for parents/caretakers is 138% of the FPL (ceiling for MACC eligibility when 5% disregard is applied) and 266% of the FPL for children (MACC ceiling including disregard). The appropriate spenddown standard for elders and adults with disabilities is the medically needy income limit adjusted for household size.

1. Spenddown Amount – The spenddown amount is calculated as follows:

a. The beneficiary's anticipated monthly net income for each month of the eligibility period based on the criteria appropriate for the specific coverage group using the SSI methodology.

b. Net income for all six (6) months.

2. FPL Comparison – The applicable six-month FPL standard is subtracted from the beneficiary's six-month net income. If the result is:

a. Equal to or less than the FPL standard, the applicant is eligible for Medicaid without a spenddown, even if they exceed the monthly FPL standard in one or more months of the six-month period. No further calculation is necessary.

b. Greater than the FPL standard continue, further calculations are required.

3. Six-month Spenddown Amount – The six-month spenddown amount is determined by subtracting the applicable six-month FPL spenddown standard from the total six-month net income. The result is the six-month spenddown amount.

4. Application of Allowable Expenses – Allowed health care expenses are applied to the six-month spenddown amount. If the applicant will incur bills to satisfy the spenddown after the date the application is processed, the final processing will be delayed until after the applicant has received the health care services. Pre-approval of certain remedial and Medicaid LTSS services is required if the MN beneficiary does not qualify for an LTSS preventive level of care.

2.4 Six-Month Spenddown Renewal

Upon renewal, a six-month spenddown is calculated in the same manner.

2.5 Allowable Expenses

A. Allowable health care expenses are those that are incurred by the beneficiary or other allowable family member(s) that are not subject to payment by a third party and may be:

1. Paid or unpaid health care bills incurred in the current eligibility period; and

2. Unpaid bills incurred prior to the current eligibility period.

B. The portion of a bill used to meet a previous spenddown cannot be used again in future spenddown calculations, unless the entire eligibility period was denied.

1. Allowable health care expenses – Such expenses include, but are not limited to: physician /health care provider visits; health insurance premiums, co-pays, co-insurance, and deductibles; dental and vision care; chiropractic and podiatric visits; prescription medications; tests and X-rays; acute hospital and nursing care; home nursing care, such as personal care attendants, private duty nursing and home health aides; audiologists and hearing aids; dentures; durable medical

equipment such as wheelchairs and protective shields; therapy, such as speech, physical, or occupational therapy; transportation for medical care, such as car, taxi, bus or ambulance; and LTSS expenses at home or in a health institution at the State Medicaid reimbursement rate.

2. Conditions on application -- An expense is allowable for the Medicaid spenddown if it is for health insurance costs or specific types of Medicaid non-covered and covered services. The scope, amount and duration of the service determines whether it qualifies as an allowable expense as a Medicaid covered or non-covered service and, therefore, the order in which it is deducted from excess income. The sequences of deductions for allowable expenses is as follows:

a. Health insurance expenses. The costs for maintaining insurance coverage for health care services and supports for both the person seeking coverage and any dependents. Includes, premiums, co-pays, co-insurance and deductibles including for Medicare and commercial plans. Premiums for optional supplemental plans are not allowable expenses.

b. Non-Medicaid expenses. These are expenses incurred for health care and remedial services that are recognized under State law but are not covered under the Medicaid State Plan or the State's Section 1115 demonstration waiver such as home stabilization services and non-medical transportation.

c. Excess Medicaid expenses. Includes expenses incurred for Medicaid covered services that exceed limitations on amount, duration, or scope established in the State Plan or Section 1115 demonstration waiver. Expenses allowed in this category must be medically necessary and include both the costs incurred for an expanded service (such as dentures, in-patient behavioral health care for an extended period, contact lenses or a second pair of prescription reading glasses) and associated ancillary health costs (x-rays, needs assessments, lab tests, office visits and the like).

d. Covered Medicaid expenses. These are incurred expenses that do not exceed limitations on amount, duration, or scope allowed under current federal authorities. They are deducted in chronological order based on the date of service beginning with the oldest expense.

(1) An expense incurred in a month for which MN eligibility is approved is presumed to be a Medicaid covered expense unless documentation is provided to the State that it is not a covered service.

(2) When a person is receiving a service or set of services Medicaid pays for in a daily or bundled rate, the items and services included in that rate are not separate allowable expenses.

e. Health institution expenses. Under the existing Medicaid State Plan, Rhode Island has taken the option under 42 C.F.R. § 435.831(3)(g)(1) to allow LTSS expenses incurred for both HCBS and health institutional care to be deducted from excess income. In accordance with the applicable federal requirements therein, the maximum amount allowed is the State Medicaid reimbursement rate projected to the end of the budget period.

f. Costs related to LTSS level or remedial care, such as home nursing care/homemaker services, adult day and home stabilization may be applied to a spenddown when a beneficiary meets the LTSS preventive level of need. In all other instances, Community Medicaid MN beneficiaries must obtain per-authorization from an agency eligibility specialist to count these costs toward a spenddown.

2.6 Expense Exceptions

A. Certain health care expenses are not allowed to be deducted from income. Such expenses include, but are not limited to:

1. Premiums paid by Medicaid or paid by the MPPP as a health care expense. Applicants and beneficiaries should consider whether participation in the MPPP will adversely affect their ability to maintain MN eligibility and vice versa with the assistance of an eligibility specialist.

2. Health care expenses incurred before the first day of the six-month certification period are not eligible for Medicaid payment; the beneficiary remains responsible for those bills.

Chapter 40 - Medicaid for Elders and Adults with Disabilities

Subchapter 05 - Community Medicaid

Retroactive Coverage (210-RICR-40-05-3)

3.1 Scope and Purpose

Medicaid coverage may start retroactively for up to three (3) months prior to the month of application for IHCC groups, unless explicitly excluded. To qualify, a person must have met the criteria for Medicaid eligibility during the retroactive period. Coverage generally stops at the end of the month in which a person no longer meets the requirements for eligibility. The provisions in this section do not apply to the MAGI-eligible individuals and families in the Medicaid Affordable Care Coverage (MACC) groups identified in the Medicaid Code of Administrative Rules, Affordable Care Coverage Groups, except when a person who is ineligible for coverage in one of these groups applies for MN IHCC in accordance with the provisions in Part 2 of this Subchapter.

3.2 General Provisions

A. Medicaid beneficiaries in the IHCC groups may request retroactive eligibility for up to three months prior to the month of application.

1. Eligibility criteria - To obtain retroactive coverage, applicants must meet all eligibility criteria related to the applicable IHCC group during the retroactive period. Retroactive coverage is also available to IV-E and non IV-E foster children and adoption subsidy family-related coverage groups.

a. The applicant must meet Medicaid eligibility requirements for each month in which an unpaid medical bill was incurred. Thus, retroactive eligibility may be determined for one, two, or three months of the retroactive period.

b. Only the income and resources available to the applicant in the retroactive period are used to determine eligibility. No deeming is required.

c. The following chart details beneficiaries' eligible retroactive benefits:

Persons Eligible	Eligible for Retro
IV-E and non IV-E Foster Children	Y
Adoption Subsidy Children Coverage Groups	Y
IHCC group members, excluding partial dual Qualified Medicare Beneficiaries (QMBs)	Y
Non-citizens who are eligible for emergency Medicaid	Y
LTSS beneficiaries	Y

d. At the time of application for Medicaid, if the applicant in one of these categories indicates that an unpaid health medical bill was incurred in the three-month period preceding the application, eligibility for retroactive coverage must be determined.

2. Limits - Current eligibility for Medicaid does NOT affect retroactive eligibility. A person denied Medicaid in the month of application may be eligible for retroactive coverage.

a. An applicant need not be alive when an application for retroactive coverage is made. A family member or authorized representative may sign and submit an application on the deceased person's behalf.

b. Retroactive eligibility is not available to persons who were not residents of Rhode Island in the retroactive period at the time the service was provided. Retroactive coverage applies only to unpaid medical bills for services provided within the scope of the Medicaid program. The bills must have been incurred during the three month retroactive period.

c. Note: All services provided in the retroactive period and the costs incurred are subject to the same Title XIX utilization review standards as all other medical services of the Medicaid Program.

Chapter 40 - Medicaid for Elders and Adults with Disabilities

Subchapter 10 - Managed Care

Medicaid Managed Care Service Delivery Arrangements (210-RICR-40-10-1)

1.1 Overview of this Rule

A. The purpose of this rule is describe the managed care service delivery options for Elders and Adults with Disabilities and long-term care beneficiaries. The purpose is also to set forth in clear language the respective roles and responsibilities of the Executive Office of Health and Human Services (EOHHS), beneficiaries, health plans, and other contractual entities related to managed care enrollment and service delivery for Elders and Adults with Disabilities and long-term care beneficiaries.

Program	Rhody Health Partners	Medicare-Medicaid Plan	PACE
Population	Elders and Adults with Disabilities who do not have Medicare or other third-party coverage; Persons without Medicare who are receiving LTSS in the home or community-based service setting, are enrolled in RHP for essential primary care services only.	Elderly and non-elderly adults who have full Medicare (Parts A, B, and D) coverage and Medicaid Health Coverage	Medicaid beneficiaries age 55 and older who qualify for a nursing home level of care
Mandatory/ Voluntary Enrollment	Mandatory	Voluntary	Voluntary
Covered Services	Medicaid	Medicaid and Medicare Parts A, B, and D	Medicaid and Medicare Parts A, B, and D (if eligible)
Participation Criteria	Age 21 and older; and Eligible for Medicaid Health Coverage on the	Age 21 and older; Eligible for Medicaid Health Coverage on the basis of the SSI income standard (IHCC group) or	Age 55 years and older; Meet criteria for high or

Program	Rhody Health Partners	Medicare-Medicaid Plan	PACE
	basis of the SSI income standard (IHCC group)	the MAGI income standard (MACC group); and Enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D	highest need for a nursing facility level of care; and Meet all other requirements for LTSS

1.2 Definitions

A. For the purpose of this rule, the following terms are defined as follows:

1. “Appeal” means a request to review an “adverse benefit determination” based on medical necessity, appropriateness, health care setting, and effectiveness.

2. “Categorical eligibility” means an applicant/beneficiary included in an IHCC group who is eligible for Medicaid health coverage on the basis of income, resources, a characteristic, and/or a level of need in a mandatory or optional coverage group under the Medicaid State Plan, or who is treated as such, under the State’s Section 1115 demonstration waiver, in accordance with Title XIX. It excludes persons who must spenddown to become eligible for Medicaid health coverage as medically needy.

3. “Elders and adults with disabilities" or "EAD” means the Medicaid IHCC group established by R.I. Gen. Laws Chapter 40-8.5 for adults with an SSI characteristic related to age (elders 65 years of age or older) or disability.

4. “Executive Office of Health and Human Services" or "EOHHS” means the state agency that is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Title XIX Medicaid Program.

5. “Full dual eligible” means a beneficiary who is enrolled in Medicare Parts A and B and is eligible for Medicaid Health Coverage through an IHCC or MACC group for elders and adults with disabilities on the basis of income, resources and, when applicable, a characteristic or need for LTSS.

6. “Grievance” means an expression of dissatisfaction about any matter other than an action associated with an adverse benefit determination and includes complaints about the quality of care or services provided, and aspects of interpersonal relations such as rudeness of a provider or an employee or a failure to respect an enrollee’s rights.

7. “Integrated Health Care Coverage Group” or "IHCC" means any Medicaid coverage group consisting of adults who are eligible on the basis of receipt of

Supplemental Security Income (SSI), SSI protected status, the SSI income methodology and a related characteristic (age or disability), or as a result of participation in another federal or State program (e.g., Breast and Cervical Cancer). Includes beneficiaries eligible for community Medicaid (non-long-term care), Medicaid-funded LTSS, and the Medicare Premium Payment Program (MPP).

8. “Integrated Care Initiative" or "ICI” means a Medicaid initiative that delivers integrated and coordinated services to certain Medicaid and Medicare enrolled (MME) beneficiaries through a managed care arrangement. The ICI includes services from across the care continuum including primary, subacute, and long-term care. The Medicare-Medicaid Plan (MMP) was established through ICI.

9. “Long-term services and supports" or "LTSS” means a spectrum of services covered by the Rhode Island Medicaid program that are required by individuals with functional impairments and/or chronic illness, and includes skilled or custodial nursing facility care, as well as various home and community-based services.

10. “Managed care arrangement" or "MCA” means a system that may use capitated financing to deliver high quality services and promote and optimize health outcomes through a medical home. Such an arrangement also includes services and supports that optimize the health and independence of beneficiaries who are determined to need or be at risk for Medicaid funded LTSS. An MCA includes any arrangement under which an MCO or contracted entity is granted some or all of the responsibility for providing and/or paying for long-term care services and supports through a contractual agreement with the Medicaid program.

11. “Managed care organization" or "MCO” means an entity that provides health plan(s) that integrate an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and emphasizes preventive and primary care.

12. “Medicaid Affordable Care Coverage Groups” 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 as outlined in Part 30-00-1 of this Title.

13. “Medicaid and Medicare enrolled" or "MME” means full dual eligible or partial dual eligible plus beneficiaries who are receiving Medicaid health coverage, are enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D.

14. “Medicaid health coverage” means the full scope of health care services and supports authorized under the State’s Medicaid State Plan and/or Section 1115 demonstration waiver provided through an authorized Medicaid delivery system.

The term encompasses the scope of health coverage available to categorically and medically needy eligible beneficiaries as well as those who are treated as such under the State's Section 1115 demonstration waiver. However, the term does not apply to partial dual eligible persons who, under the provisions of this section, qualify only for financial assistance through the MPPP to help pay Medicare cost-sharing.

15. "Medically necessary service" means a medical, surgical, or other service required for the prevention, diagnosis, cure, or treatment of a health- related condition including any such services that are necessary to prevent or slow a decremental change in either medical or mental health status.

16. "Medically needy" means an IHCC group for elders and persons with disabilities who have high medical expenses and income that exceeds the maximum eligibility threshold for Medicaid. For non-LTSS beneficiaries in this coverage group, Medicaid eligibility and coverage occur when the amount they spend on medical expenses meets the medically needy income limit established by the State. For LTSS beneficiaries, excess income must be contributed toward the cost of care. Non-LTSS medically needy beneficiaries are covered on a fee-for-service basis.

17. "Medicare-Medicaid Plan" or "MMP" is an integrated managed care plan under contract with the federal Centers for Medicare and Medicaid Services (CMS) and EOHHS to provide fully integrated Medicare and Medicaid benefits to eligible MME beneficiaries.

18. "Member" or "Enrollee" means a Medicaid-eligible person receiving benefits through Rhody Health Partners, a Medicare-Medicaid Plan, or the Program for All-Inclusive Care for the Elderly.

19. "Partial dual eligible" means a Medicare beneficiary who does not meet the requirements for Medicaid Health Coverage, but who is eligible for the State's Medicare Premium Payment Program (MPP).

20. "Partial dual eligible plus" means a Medicare beneficiary who is eligible for Medicaid health coverage as medically needy and the MPP.

21. "Person-centered planning" means an individualized approach to planning that supports an individual to share his or her desires and goals, to consider different options for support, and to learn about the benefits and risks of each option. Person-centered planning places the individual at the center of decision-making. It is designed to enable people to direct their own services and supports to live a meaningful life that maximizes independence and community participation. Person-centered planning is a process that is directed by the individual, with impartial assistance and supported decision-making when helpful. Person-centered planning teams may include people who are close to the individual, as well as people who can help to bring about needed change for the person and

access to appropriate services. However, at all times, the individual is empowered to decide who is part of the planning team. Person-centered planning must meet the requirements of 42 C.F.R. § 441.301(c)(1) including, but not limited to, ensuring that a person has sufficient and necessary information in a form he or she can understand to make informed choices, enabling the person to direct the process to the maximum extent possible, and conducting planning meetings at times and in locations that are convenient to the individual.

22. “Primary care” means an array of primary, acute, and specialty services provided by licensed health professionals that includes, but is not limited to: health promotion, disease prevention, health maintenance, counseling, patient education, various specialty services and diagnosis and treatment of acute and chronic medical and behavioral health illnesses and conditions in a variety of health care settings (e.g., office, inpatient, care, home care, day care).

23. “Program of All Inclusive Care for the Elderly" or "PACE” means a risk-based managed care service delivery option for beneficiaries who have Medicare and/or Medicaid coverage and meet the financial and clinical criteria for a nursing facility level of long-term services and supports. Beneficiaries must be 55 years or older to participate in this option.

24. “Rhody Health Options” or “RHO” means the capitated managed care delivery system operating under contract with EOHHS to manage and coordinate Medicaid covered services and supports, including LTSS, for eligible MNM and MME beneficiaries and to coordinate Medicaid covered services with Medicare covered services for eligible MME beneficiaries. RHO terminates as service delivery option on September 30, 2018.

25. “Rhody Health Partners" or "RHP” means the Medicaid managed care service delivery option for adults in the IHCC groups that provides primary/acute and specialty care through a medical home that focuses on prevention and promoting healthy outcomes. The rules for RHP for adults ages 19-64 in the MACC groups are located in Part 30-05-2 of this Title.

26. “SSI income standard” means the basis for determining Medicaid eligibility that uses the definitions and calculations for evaluating income and resources established by the U.S. Social Security Administration for the Supplemental Security Income (SSI) program.

27. “SSI protected status” means the class of beneficiaries who retain categorical eligibility for Medicaid even though they are no longer eligible for SSI due to certain changes in income or resources.

1.3 Rhody Health Partners (RHP)

1.3.1 Authority and Scope

A. In 2005, R.I. Gen. Laws § 40-8.5-1.1 authorized the Medicaid agency to establish mandatory managed care delivery systems for adults nineteen (19) years of age or older who are eligible on the basis of participation in the Supplemental Security Income (SSI) program (see § 00-1.5 of this Chapter) or an SSI-related characteristic associated with age or a disability and income. In Rhode Island, persons with SSI-related characteristics are eligible under the Medicaid State Plan option for low-income elders and adults living with disabilities (EAD) in accordance with R.I. Gen. Laws Chapter 40-8.5. The requirements for adults in associated special eligibility groups that have unique financial (e.g., SSI Protected Status) or clinical criteria (e.g., breast and cervical cancer coverage group) or limited benefits (e.g., partial dual eligible group and the Medicare Premium Payment Program) are also located in § 05-1.6 of this Chapter.

B. Beneficiaries eligible in these coverage groups who do not require LTSS are sometimes referred to as "Community Medicaid" and are members of the State's Integrated Health Care Coverage (IHCC) groups. The provisions governing eligibility set forth in Subchapter 05 Part 1 of this Chapter and § 00-3.1.2 of this Chapter and enrollment as established herein will remain in effect unless or until replaced.

C. IHCC group beneficiaries who are eligible on the basis of SSI income standard, do not require LTSS, and do not have third-party coverage are subject to mandatory enrollment in a Rhody Health Partners (RHP) Medicaid managed care plan. Eligible beneficiaries have the choice of two-RHP participating health plans.

1.3.2 EOHHS Responsibilities

A. EOHHS, or its designee, is responsible for determining the eligibility of members in the IHCC groups in accordance with requirements established in the applicable sections of federal and State laws, rules and regulations unless deemed eligible by virtue of receipt of SSI. In general, persons will be informed of their enrollment options at the time a determination of eligibility is made.

B. IHCC group beneficiaries who are eligible on the basis of SSI income standard, do not require LTSS, and do not have third-party coverage are subject to mandatory enrollment in an RHP Medicaid managed care plan. EOHHS enters into contractual arrangements with the MCOs offering RHP plans that assure access to high quality Medicaid covered services and supports. EOHHS is also responsible for informing beneficiaries of their service delivery options and initiating enrollment in a participating RHP plan.

1.3.3 RHP Enrollees

A. Enrollment in an RHP plan typically occurs no more than thirty (30) days from the date of the determination of eligibility unless excluded from enrollment.

B. Excluded from RHP enrollment. Beneficiaries in the following categories are excluded from enrollment in an RHP plan and may be enrolled in an alternative Medicaid managed care arrangement:

1. Third-Party Coverage – SSI and EAD eligible beneficiaries who are enrolled in Medicare Parts A and/or B or have other third-party coverage are not subject to mandatory enrollment in an RHP plan.

2. Exempt Due to Age – SSI and EAD beneficiaries who are between the ages of nineteen (19) and twenty-one (21) are exempt from mandatory enrollment in RHP and receive all Medicaid health coverage on a fee-for-service basis.

3. Medically Needy Eligible, Non-LTSS – Beneficiaries who are determined eligible as medically needy due to excess income and resources are also exempt from enrollment in managed care. Medicaid health coverage for beneficiaries in this category is provided in accordance with the provisions of Subchapter 05 Part 2 of this Chapter.

4. The excluded populations receive all Medicaid covered services on a fee-for-service basis, unless they are otherwise eligible for another Medicaid delivery system. In addition, during the period while awaiting plan enrollment, beneficiaries eligible for RHP receive health coverage on a fee-for-service basis.

1.3.4 RHP Enrollment Process

A. RHP-eligible beneficiaries have the choice of two participating plans. EOHHS employs a formula, or algorithm, to assign prospective enrollees to a health plan. Eligible beneficiaries are sent a letter from EOHHS at least forty-five (45) days prior to the enrollment effective date notifying them of their health plan assignment and the enrollment effective date. The letter also includes information on their health plan choices. Beneficiaries are given at least thirty (30) days to review the health plan enrollment assignment and request a change. At the end of this timeframe, EOHHS enrolls the beneficiary, effective the first day of the following month, as follows:

1. Beneficiary Action – If the beneficiary makes a choice to change health plan assignment, EOHHS initiates enrollment, as appropriate, into the selected RHP plan.

2. No Beneficiary Action – If a beneficiary does not respond within the allotted timeframe, the beneficiary is enrolled in the assigned RHP plan.

3. Delivery System Changes –Enrollment into RHP is always prospective in nature. Medicaid beneficiaries are required to remain enrolled in this service delivery option, but they can request reassignment to another plan within the first ninety (90) days of enrollment. They are also authorized to transfer from one MCO to another once a year during an open enrollment period. Medicaid enrollees who challenge an auto-assignment decision or seek to change plans more than ninety (90) days after enrollment in the health plan must submit a written request to the Medicaid agency and show good cause, as provided in Subchapter 00 Part 2 of this Chapter for reassignment to another plan. A written decision must be rendered by the Medicaid agency within ten (10) days of

receiving the written request and is subject to appeal, as described in Part 10-05-2 of this Title. If a beneficiary becomes eligible for LTSS and:

a. Does not have Medicare, essential primary care services through RHP are continued if the LTSS is provided in a home or community-based setting; in such cases, all LTSS is provided on a fee-for-service basis. If LTSS is provided in a health institution such as a nursing facility, EOHHS initiates RHP disenrollment and all Medicaid covered services, including essential primary care services and LTSS are provided fee-for-service;

b. Is eligible for or enrolled in Medicare, EOHHS initiates RHP disenrollment and, if eligible, offers the alternative option of enrolling in Medicaid LTSS managed care arrangements such as the Program for All-Inclusive Care for the Elderly (PACE), a Medicare-Medicaid Plan, or a fee-for-service (FFS) alternative.

4. Auto Re-Assignment after Resumption of Eligibility – Medicaid beneficiaries who are disenrolled from RHP due to a loss of eligibility and who regain eligibility within sixty (60) calendar days are automatically re-enrolled, or assigned, back into the managed care service delivery option they were in previously if they do not make a plan selection. If more than sixty (60) calendar days have elapsed, the enrollment process will follow the process established in this section.

1.3.5 RHP Member Disenrollment

A. Disenrollment from an RHP plan may be initiated by EOHHS or the plan in a limited number of circumstances as follows:

1. EOHHS Initiated Disenrollment – Reasons for EOHHS-initiated disenrollment from an RHP plan include but are not limited to:

a. Death;

b. No longer Medicaid eligible;

c. Eligibility error;

d. Enrolled in Medicare or other third-party coverage;

e. Placement in a long-term care institution – such as a nursing facility – for more than thirty (30) consecutive days;

f. Placement in Eleanor Slater, Tavares, or an out-of-state hospital;

g. Incarceration; or

h. Eligibility for Medicaid LTSS in a facility.

2. Member Disenrollment Requested by RHP plan – An RHP plan may request in writing the disenrollment of a member whose continued enrollment seriously impairs the plan's ability to furnish services to either the particular member or to other members. An RHP plan is not permitted to request disenrollment of a member due to:

a. An adverse change in the member's health status;

b. The member's utilization of medical services; or

c. Uncooperative behavior resulting from the member's special needs.

3. All plan-initiated disenrollments are subject to approval by EOHHS, after an administrative review of the facts of the case has taken place. Beneficiaries have the right to appeal EOHHS' disenrollment decision (see Part 10-05-2 this Title). EOHHS will determine the disenrollment date as appropriate, based on the results of this review.

1.3.6 Grievances, Appeals and Hearings

A. Federal law requires that Medicaid MCOs have a system in place for enrollees that includes a grievance process, an appeal process, and access to an administrative fair hearing through the State Administrative Fair Hearing Process. For in-plan services, RHP members must exhaust the internal MCO Level I and Level II appeals process before requesting an EOHHS hearing. Regulations governing the appeals process for out-of-plan services are found in Part 10-05-2 of this Title.

1. Types of Internal Appeals – The plan must maintain internal policies and procedures to conform to state reporting policies and implement a process for logging appeals. Appeals filed with a managed care plan fall into three (3) categories:

a. Medical Emergency. An MCO must decide the appeal within seventy-two (72) hours when a treating provider, such as a doctor who takes care of the member, determines the care to be an emergency and all necessary information has been received by the MCO.

b. Non-Emergency Medical Care. The two levels of a non-emergency medical care appeal are as follows:

(1) For the initial level of appeal, the MCO must decide the appeal within fifteen (15) days from the date that all necessary information is dated as received by the MCO. If the initial decision is adverse to the member, then the MCO must offer the second level of appeal.

(2) For the second level of appeal, the MCO must make a decision within fifteen (15) days of the date that all necessary information is dated as received by the MCO.

c. Non-Medical Care. If the appeal involves a problem other than medical care, the MCO must resolve the appeal within thirty (30) days of the date that all necessary information is dated as received by the MCO.

2. External Appeal. RHP members who exhaust the health plan's internal appeal processes may choose to initiate an "external appeal," in accordance with the Rhode Island Department of Health's Rules and Regulations for the Utilization Review of Health Care Services (216-RICR-40-10-20). A member does not have to exhaust the third level appeal before accessing an EOHHS hearing.

3. Regulations governing the appeals process are found in Part 10-05-2 of this Title.

1.4 RHP Benefit Package

A. The IHCC groups participating in RHP under this section receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver. Covered services may be provided through the managed care plan or through the fee-for-service delivery system if the service is "out-of-plan" – that is, not included in the managed care plan but covered under Medicaid. Fee-for-service benefits may be furnished either by the managed care provider or by any participating provider.

1. Access to Benefits – Each RHP member selects a primary care provider (PCP) who performs necessary medical care and coordinates referrals to specialty care. The PCP orders treatment determined to be medically necessary in accordance with the health plan's policies. Prior authorization rules may apply, as required by the Medicaid agency.

2. Delivery of Benefits – In-plan services are paid for on a capitated basis.

3. Medical Necessity – The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered service is required and appropriate. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

4. Medicaid Benefits – The coverage provided through RHP is categorized as follows:

RHP Benefits	
(a) In-Plan	**(b) Out-of-Plan**
Inpatient Hospital Care	Dental Services
Outpatient Hospital Services	Court-ordered Mental Health and Substance Abuse Services Ordered to a Non-Network Facility or Provider
Physician Services	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS' non-emergency transportation broker.)
Family Planning Services	Nursing home Services in Excess of 30 Consecutive Days
Prescription Drugs	Residential Services for Beneficiaries with Intellectual and Developmental Disabilities
Non-Prescription Drugs	
Laboratory Services	Center of Excellence for Opioids
Radiology Services	Peer Recovery Specialist
Diagnostic Services	Recovery Navigation Program (RNP) Long-term care services and supports after 30 days
Outpatient & Inpatient Mental Health and Substance Use Services	
Court-ordered Mental Health and Substance Abuse Services – Criminal Court	
Court-ordered Mental Health and Substance Abuse Treatment – Civil Court	
Home Health Services	

RHP Benefits	
(a) In-Plan	**(b) Out-of-Plan**
Emergency Room Service and Emergency Transportation Services	
Nursing Home Care and Skilled Nursing Facility Care for the first 30 days	
Services of Other Practitioners	
Podiatry Services	
Optometry Services	
Oral Health	
Hospice Services	
Durable Medical Equipment	
Group/Education Programs	
Interpreter Services	
Transplant Services	
Adult Day Services	
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS and those at High Risk for Acquiring HIV	
AIDS Medical Case Management	
Opioid Treatment Provider Health Home	

RHP Benefits	
(a) In-Plan	**(b) Out-of-Plan**
Preventive services, including: Homemaker Minor Environmental Modifications Physical Therapy Evaluation and Services	

1.5 Integrated Care Initiative (ICI)

1.5.1 Authority and Overview

A. In accordance with R.I. Gen. Laws Chapter 40-8.13, the State's Section 1115 Waiver Demonstration, and other federal waivers and authorities, EOHHS has developed and implemented the ICI to expand access to comprehensive care management and services through a managed care delivery system known as the Medicare-Medicaid Plan (MMP).

B. Under the authority of a special federal Financial Alignment Demonstration, the MMP integrates and coordinates Medicare and Medicaid covered services through a managed care arrangement for MME beneficiaries. Enrollment is voluntary for eligible beneficiaries. The operations of the MMP are bound by a three-way agreement between EOHHS, the federal Centers for Medicare and Medicaid Services (CMS), and the participating MCO.

1.5.2 EOHHS Responsibilities

A. As the single State agency for Medicaid, EOHHS oversees administration of the program and is responsible for ensuring that eligibility determinations and enrollment procedures are conducted in accordance with applicable federal and State laws and regulations. To enroll in the MMP, applicants must qualify as an MME in accordance with the applicable provisions set forth herein. Enrollment in PACE is a standing option for eligible beneficiaries. Applicants are processed as summarized below:

1. Eligibility Determinations – EOHHS or its designee is responsible for determining the eligibility of applicants for Medicaid and Medicaid-funded LTSS, including those who have third party coverage through Medicare. All LTSS applicants must meet financial and clinical criteria related to the need for an institutional level of care set forth in Part 50-00-5 of this Title and Medicaid Code of Administrative Rules, Section #0380, "Resources Generally"; #0382,

"Evaluation of Resources"; #0384 "Resource Transfers"; #0386, "Income Generally"; #0388, "Treatment of Income." The eligibility duties of EOHHS also include:

a. Level of Need. EOHHS applies clinical criteria to determine whether and to what extent the needs of an applicant/beneficiary require the level of care provided in an institutional setting – nursing facility, hospital, intermediate care facility for intellectual disabilities. EOHHS is also responsible for identifying beneficiaries for whom there is unlikely to be an improvement in functional/medical status.

b. Beneficiary Liability. EOHHS determines the amount LTSS beneficiaries must pay toward the cost of the care – beneficiary liability – through a process referred to as the post-eligibility treatment of income (PETI). All beneficiaries of Medicaid-funded LTSS are required under the Medicaid State Plan and the State's Section 1115 Waiver to contribute to the cost of the services they receive to the full extent their income and resources allow, irrespective of care setting or service delivery option. Failure to make such payments may result in termination of eligibility for non-cooperation (See Part 50-00-8 of this Title).

c. Person Centered Planning and Service Arrangements. In addition to determining eligibility and beneficiary liability for Medicaid LTSS, EOHHS is responsible for engaging beneficiaries in person-centered care planning in which the beneficiary leads an assessment and discussion of his or her needs and goals and information about various care options. This process includes the development of a service plan that corresponds to the beneficiary's needs and goals and assists beneficiaries and their families in selecting the appropriate service delivery option and making care arrangements.

2. Service Delivery Options and Enrollment – EOHHS assures that every beneficiary has access to health coverage through the service delivery options provided for in federal and State law that most appropriately meet his or her needs. Once a determination of eligibility has been made, beneficiaries are evaluated for enrollment in managed care versus fee-for service.

1.5.3 Service Delivery Options

A. EOHHS provides the following delivery options to Medicaid beneficiaries who meet program participation criteria:

1. Medicare-Medicaid Plan (MMP) – The MMP is a managed care service delivery system designed to manage and coordinate the full spectrum of both Medicaid and Medicare services for Medicare and Medicaid (MME) adults. See § 1.7 of this Part for more information on the MMP.

2. PACE – PACE is a service delivery option for beneficiaries who have Medicare and/or Medicaid coverage and meet a “high” or “highest” level of need for LTSS in accordance with Part 50-00-5 of this Title. Beneficiaries must be 55 years old or older to participate in this option. See § 1.13 of this Part for more information on PACE.

3. Fee-for-service – Beneficiaries participating in the MMP receive at least some of their Medicaid health coverage on a fee-for-service basis. Beneficiaries eligible for the MMP, and PACE also have the option to obtain all of their Medicaid covered services on a fee-for-service basis.

4. Care Management Entity provide care coordination and assistance to beneficiaries in Medicaid fee-for-service who are not eligible for enrollment in managed care. The Care Management Entity provides beneficiaries assistance with:

a. Navigating the health care system

b. Care management, client advocacy, and health education

c. Working with a person’s primary care provider and

d. Provides links to community resources.

5. Participation in Care Management is voluntary. The State targets eligible beneficiaries for care management based upon clinical need and functional status.

1.6 Rhody Health Options (RHO)

A. In accordance with Section 7 of Pub. Law 18-047 enacted on June 22, 2018, Medicaid beneficiaries enrolled in RHO on and before October 1, 2018 will be placed in fee-for-service arrangements effective that date for all Medicaid covered long-term services and supports. The RHO program termination date is September 30, 2018.

B. Medicaid beneficiaries who were enrolled in RHO on and before October 1, 2018 will continue to receive all medically necessary services as contained in § 1.4(A)(4) of this Part. The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered service is required and appropriate. Prior to the termination date of RHO for existing beneficiaries and after for all new beneficiaries, any member who is dually eligible for Medicaid and Medicare may be enrolled in a MMP while retaining the choice to opt out and receive LTSS on a fee-for service basis. For Medicaid beneficiaries who do not have Medicare, the transition is as follows:

1. Medicaid-only LTSS in a home and community-based setting --Beneficiaries who are seeking or receiving LTSS in a home and community-based setting as defined in Part 50-10-1 of this Title will receive all essential primary care benefits

through a Rhody Health Partners managed care plan. Medicaid LTSS will be provided out-of-plan and paid for on a fee-for-service basis after the first 30 days.

2. Medicaid-only LTSS in a health institution --Persons seeking or receiving Medicaid in an institutional setting such as a nursing facility or hospital in accordance with Part 50-05-1 of this Title will be receive all Medicaid-covered services (primary care, subacute care, long-term services and supports) on a fee-for-service basis.

1.6.1 RHO Appeals

The class of Medicaid beneficiaries who were enrolled in RHO on and before October 1, 2018 do not have the right to appeal the termination of their RHO coverage in accordance with 42 C.F.R. § 431.220 (b) and § 10-05-2.2.1(A)(7)(a) of this Title. The right to appeal agency actions unrelated to this change in law and policy that affect eligibility, or the scope, amount, and or duration of Medicaid benefits is preserved.

1.7 Medicare-Medicaid Plan (MMP)

1.7.1 Overview

Under the authority of a special federal Financial Alignment Demonstration, the MMP is designed to manage and coordinate the full spectrum of both Medicaid and Medicare services for Medicare and Medicaid (MME) adults. Enrollment is voluntary for eligible beneficiaries. A three-way agreement between EOHHS, the MCO operating the MMP, and the federal Centers for Medicare and Medicaid Services (CMS) governs the organization, financing, and delivery of Medicaid and Medicare services to MME beneficiaries who choose to participate.

1.7.2 MMP Participation Criteria

A. MME beneficiaries are eligible for participation in the MMP if they are age twenty-one (21) and older as follows:

1. MME Enrollees – Medicare-Medicaid beneficiaries who are receiving Medicaid health coverage, enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D. This cohort includes MME and other Community Medicaid IHCC group beneficiaries as well as those who need LTSS. Eligible MME beneficiaries include:

a. Members of the IHCC groups receiving Community Medicaid, including persons with serious and persistent mental illness, who do not need LTSS;

b. MAGI-eligible adults in the MACC group for parents/caretakers;

c. LTSS recipients residing in institutional or home and community-based settings including those qualifying for the level of care provided in a

nursing facility and intermediate care facility for persons with intellectual disabilities (ICF-ID) – such as nursing facility, assisted living and ID group home residents as well as those residing in their own homes; and

d. Persons with End Stage Renal Disease (ESRD) at the time of enrollment.

2. MME beneficiaries are entitled to Medicaid State Plan and Section 1115 waiver services that are not covered by Medicare.

3. Excluded Beneficiaries – Certain Medicaid beneficiaries are excluded from participating in the MMP as indicated below:

a. Beneficiaries excluded from the MMP.

b. Medicare beneficiaries who are not eligible for Medicaid health coverage, including partial dual eligible beneficiaries who participate in the Medicaid Premium Payment Program (MPP) as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Beneficiaries (SLMBs), and Qualifying Individuals (QIs).

c. Dual Eligible beneficiaries who are not qualified to enroll in all segments of Medicare.

d. Medicaid beneficiaries residing in Tavares, Eleanor Slater, or out-of-state hospitals.

e. Beneficiaries who are in hospice on the effective enrollment date. Enrollees who elect hospice care after they are enrolled in the MMP can remain in the MMP.

f. Beneficiaries who reside out-of-state for six (6) consecutive months or longer.

g. Beneficiaries who are eligible for the Medicaid Buy-In Program for Working People with Disabilities (known as the "The Sherlock Plan" in Rhode Island).

h. Dual eligible beneficiaries who are between the ages of nineteen (19) and twenty (20) are exempt from enrollment in managed care and receive all Medicaid health coverage on a fee-for-service basis.

i. Beneficiaries who are determined eligible as medically needy for Community Medicaid due to excess income and resources are exempt from enrollment in managed care.

1.7.3 MMP Service Delivery Option

MMP participating beneficiaries receive services through a managed care arrangement operating under contract with EOHHS and CMS. MMP enrollees receive services through a health plan offered by an MCO. The operations of the MMP are bound by a three-way agreement with EOHHS and CMS to integrate the full range of Medicare and Medicaid services (primary care, acute care, specialty care, behavioral health care, and LTSS) in accordance with a rate structure that includes federal and state funding streams for all MME adults. Accordingly, the MMP must provide accessible, high-quality services and supports focused on optimizing the health and independence of one of the most fragile Medicaid populations. Enrollment in the MMP is voluntary.

1.7.4 MMP Enrollment

A. The MMP offers MME beneficiaries the opportunity to obtain comprehensive integrated services through a single health plan.

1. Passive or Auto-Enrollment –Eligible beneficiaries may be passively enrolled by EOHHS, or auto-enrolled, in the MMP unless they are excluded from passive enrollment on the basis of one of the following criteria:

a. The MME beneficiary is enrolled in a Medicare Advantage plan that is not operated by the same MCO as the MMP;

b. The beneficiary has been auto-enrolled by CMS into a Medicare Part D plan in the same calendar year that the MME would qualify for the MMP;

c. The MME is currently enrolled in comprehensive health insurance coverage through a private commercial plan or group health plan provided through an employer, union, or TRICARE; or

d. The beneficiary has affirmatively opted-out of passive enrollment into an MMP or a Medicare Part D plan.

2. Opt-in Enrollment –Eligible beneficiaries may be offered the option to opt into the MMP. MME beneficiaries who are not eligible for passive enrollment will be offered the opportunity to opt-in to an MMP by completing an application in writing or via phone. Individuals enrolled in PACE may elect to enroll and participate in the MMP if they choose to disenroll from PACE.

1.7.5 Enrollment Information

A. EOHHS is responsible for ensuring that all MME beneficiaries who meet the criteria to participate in the MMP have access to the information necessary to make a reasoned choice about their coverage options. As indicated in § 1.2(A)(25) of this Part, the person-centered planning process plays a critical role in ensuring that beneficiaries are aware of the full range of service delivery options available to them based on their level of need and personal goals. Accordingly, prospective participants are sent a written communication informing them of the option to enroll in an MMP, as well as information on the availability of independent enrollment options counseling and other supports to

help beneficiaries make informed enrollment decisions. Eligible individuals who opt-out of or do not enroll in an MMP have the option to enroll in PACE if eligible, or receive all Medicaid covered services – including LTSS – on a fee-for-service basis, unless they are otherwise eligible for another Medicaid delivery system.

B. Communications with MME beneficiaries who qualify to participate in the MMP includes information about each of the following:

1. Enrollment Opt-In and Opt-Out Process – Participation in an MMP is voluntary. MME beneficiaries eligible for passive enrollment are informed that they may choose to opt out of enrollment in the MMP and are provided with instructions on how to proceed. MME beneficiaries eligible for passive enrollment who opt-out may choose any of the alternative service delivery options for which they may qualify. Eligible beneficiaries who are not passively enrolled are provided with instructions on how to enroll in an MMP.

2. Decision Timeframe – Eligible beneficiaries may enroll in an operational MMP at any time up until six (6) months prior to the end of the federal demonstration under which the MMP was implemented. The federal demonstration is scheduled to end on December 31, 2020. Information is provided about enrollment decision time-frames as follows:

a. Passive Enrollment. Beneficiaries eligible for passive enrollment into the MMP are sent a first notification that they will be passively enrolled between sixty (60) and ninety (90) days prior to the effective date of enrollment; a second reminder notification is sent to the beneficiary at least thirty (30) days prior to the effective date of enrollment. If the beneficiary makes an enrollment choice within the specified timeframe, EOHHS initiates enrollment accordingly. If a beneficiary does not respond within the specified timeframe, enrollment in the MMP proceeds in accordance with the terms specified in the initial communication from EOHHS.

b. Opt-in Enrollment. MME beneficiaries who are eligible for the MMP but are not passively enrolled may be sent a notification that they have the option to enroll in an MMP. Opt-in enrollment requests received through the 10th day of the month will take effect on the first day of the following calendar month. Opt-in enrollment requests received on the 11th day of the month or later will take effect on the first day of the second month after the request was submitted. Beneficiaries do not need to make an enrollment decision to opt into the MMP within a specified timeframe after receiving notice from EOHHS informing them that they are eligible to enroll in the MMP. However, no new enrollments will be accepted during the six (6) months prior to the end date for the federal demonstration under which the MMP was implemented. The federal demonstration is scheduled to end on December 31, 2020.

3. Opportunity to Change – Beneficiaries who are being passively enrolled or who opt-in to an MMP may cancel their enrollment any time prior to their effective enrollment date. Once enrolled, beneficiaries may change service delivery options on a monthly basis at any time, but enrollment in the MMP will continue through the end of the month. The requested change will be effective on the first day of the following month. Beneficiaries who cancel enrollment into or voluntarily disenroll from an MMP will be enrolled in fee-for-service (FFS), effective the first day of the following month. Beneficiaries who voluntarily disenroll from the MMP plan can choose to re-enroll in the plan on a monthly basis if they continue to be eligible for enrollment in the MMP, but they will not be passively enrolled in the MMP. Beneficiaries may also be eligible for enrollment in PACE (see § 1.13 of this Part).

4. Auto Re-Assignment after Resumption of Eligibility – MME beneficiaries who are disenrolled from an MMP due to a loss of eligibility are eligible for re-enrollment in the plan if eligibility is reinstated and they otherwise meet the requirements for enrollment. Beneficiaries eligible for re-enrollment will be passively enrolled if they meet the requirements for passive enrollment. Otherwise, they will be offered opt-in enrollment.

1.7.6 MMP Member Disenrollment

A. EOHHS Initiated Disenrollment – Reasons for EOHHS disenrollment from an MMP include but are not limited to:

1. Death;

2. No longer eligible for Medicaid;

3. Loss of Medicare Part A and/or Part B;

4. Enrollment into a Medicare Advantage (Part C) plan or Medicare Part D prescription drug plan;

5. Eligibility error;

6. Placement in Eleanor Slater Hospital, Tavares, or out-of-state residential hospital;

7. Incarceration;

8. Changed state of residence;

9. Enrollment in PACE; and

10. Opt-out to fee-for-service.

B. Beneficiaries who are involuntarily disenrolled because of incarceration are provided Medicaid coverage on a fee-for-service basis. Beneficiaries who are involuntarily disenrolled for any other reason and remain eligible for Medicaid coverage are enrolled in FFS.

C. Medicare-Medicaid Plan Disenrollment Request – The Medicare-Medicaid plan may make a written request to EOHHS and CMS asking that a particular member be disenrolled. Any such request is only considered by EOHHS and CMS when made on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members, the member knowingly provided fraudulent information on the MMP enrollment form that materially affected his or her eligibility to enroll in the MMP, or the member intentionally permitted others to use his or her member identification card to obtain services under the MMP. EOHHS and CMS do not permit disenrollment requests based on:

1. An adverse change in the member's health status;

2. The member's utilization of medical services;

3. Uncooperative or disruptive behavior resulting from the member's special needs;

4. The member exercising treatment decisions with which the MCO or the MCO's provider(s) disagree; or

5. Diminished or diminishing mental capacity of the member.

D. Beneficiaries who are involuntarily disenrolled based on a written request by the MMP receive their Medicaid benefits on a fee-for-service basis.

E. Disenrollment Review – All disenrollments are subject to approval by EOHHS and CMS. Beneficiaries have the right to appeal EOHHS' and CMS' disenrollment decision (see Part 10-05-2 of this Title). EOHHS and CMS determine jointly the disenrollment date as appropriate.

1.7.7 Grievances, Appeals and Hearings

A. MMP members have multiple avenues for contesting decisions that affect their health coverage, including EOHHS and CMS administrative fair hearings. The process is as follows:

1. MMP Grievances – Grievances directed toward the MMP may be internal or external.

a. Internal or plan level grievances. MMP members, or their authorized representatives, can file a grievance with the MCO or a participating provider at any time by calling or writing the MCO or the provider. The MCO must require providers to forward grievances to the MCO. If the

MMP member is requesting remedial action related to a Medicare issue, the member must file the grievance with the MCO or the provider no later than sixty (60) days after the event or incident triggering the incident (see Part 2 of Subchapter 05 of Chapter 10 of this Title). The MCO must respond, orally or in writing, to an internal grievance within thirty (30) days after the MCO receives the grievance. The MCO must respond, orally or in writing, within twenty-four (24) hours whenever the MCO extends the timeframe for a decision or refuses to grant a request for an expedited grievance.

b. External. MMP members, or their authorized representatives, can file a grievance by contacting 1-800-MEDICARE or EOHHS. Any grievance filed with EOHHS will be reviewed by a joint EOHHS-CMS contract oversight team and be made available to the MCO.

2. MMP Appeals – The process for handling appeals varies depending on whether the beneficiary is disputing an action related to Medicaid or Medicare coverage. For services covered under Medicare Part D, MMP members must follow the appeals process established by CMS in Subparts M and U of 42 C.F.R. Part 423. For services covered by Medicare Part A, Medicare Part B, and/or Medicaid in-plan services, MMP members must complete one level of internal appeal before requesting an external review. Regulations governing the appeals process for Medicaid out-of-plan services are found in Part 10-05-2 of this Title. The process for filing subsequent appeals after the first level internal appeal is as follows:

a. Services covered by Medicare Part A and/or B. Subsequent appeals after the first level internal appeal for traditional Medicare A and B services that are not fully in favor of the enrollee will be automatically forwarded to the Medicare Independent Review Entity (IRE) by the MMP.

b. Services covered by Medicaid only. Subsequent appeals for services covered by Medicaid only (including, but not limited to, LTSS and behavioral health) may be made to the EOHHS Hearing Office and/or to the Rhode Island External Review Entity per State regulations (216-RICR-40-10-20) after the first plan-level Appeal has been completed. If an appeal is filed with both the Rhode Island External Review Entity and the EOHHS Hearing Office, the MCO will be bound by any determination in favor of the member that is closest to the relief requested by the member. Appeals related to drugs excluded from Medicare Part D that are covered by Medicaid must be filed with the MMP in accordance with Part 10-05-2 of this Title, and Subchapter 00 Part 2 of this Chapter, and the requirements contained herein.

c. Services covered by both Medicare and Medicaid. After the first level internal appeal, appeals for services for which Medicare and Medicaid overlap (including, but not limited to, home health, durable medical

equipment, and skilled therapies, but excluding Part D) will be auto-forwarded to the IRE by the MMP.

d. After the first plan-level appeal for Medicare and Medicaid overlapping services, a member may file a request for a hearing with the EOHHS State Fair Hearing Office. After the first plan-level appeal for Medicare and Medicaid overlap services, a member may also file a request for a hearing with the Rhode Island External Review Entity per State regulations (216-RICR-40-10-20). If an appeal is filed with both the IRE and either the Rhode Island External Review Entity or the EOHHS Hearing Office, the MCO will be bound by any determination in favor of the member that is closest to the relief requested by the member.

3. Internal appeals timeframes

a. First Level. An MMP member must file a first-level internal appeal with the plan within sixty (60) calendar days following the date of the notice of adverse action that generates the appeal.

b. Standard appeals. For first-level internal appeals, the MMP must render a decision within thirty (30) calendar days of the date that the appeal request has been received by the managed care entity. The MMP can extend the deadline for a decision by up to fourteen (14) days if requested by the beneficiary or if the delay is in the beneficiary's best interest.

c. Expedited appeals. For first -level internal appeals, the MMP must render a decision within seventy-two (72) hours of the date that the appeal request has been received by the managed care entity when either the MMP or the member's provider determines that standard appeal resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The MMP can extend the deadline for a decision by up to fourteen (14) days if requested by the beneficiary or if the delay is in the beneficiary's best interest.

1.7.8 MMP Benefit Package

A. The MMP provides a comprehensive benefit package to members that includes a full continuum of Medicare and Medicaid services as follows:

1. Medicare – Medicare Parts A, B, and D-funded medically necessary services.

2. Medicaid Services – The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered service is required and appropriate. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider. Medicaid services may be in-plan or out-of-plan. In-plan services are paid for on a capitated basis. Certain

Medicaid-covered services are considered "out-of-plan" and are provided on a fee-for service basis. The MMP is not responsible for delivering or reimbursing out-of-plan services but is expected to coordinate in-plan services with out-of-plan services. Out-of-plan services are provided by existing Medicaid-approved providers who are reimbursed directly by Medicaid on a fee-for-service basis. The Medicaid coverage provided through the MMP is categorized as follows:

MMP Medicaid Benefits			
(a) In-Plan		**(b) Out-of-Plan**	
(01)	Inpatient Hospital Care	(01)	Dental Services
(02)	Outpatient Hospital Services	(02)	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS' non-emergency transportation broker)
(03)	Physical Therapy Evaluation and Services	(03)	Residential Services for Clients with Intellectual and Developmental Disabilities
(04)	Physician Services	(04)	
(05)	Care Management Services		
(06)	Family Planning Services		
(07)	Prescription Drugs		
(08)	Non-Prescription Drugs		
(09)	Laboratory Services		
(10)	Radiology Services		
(11)	Diagnostic Services		
(12)	Mental Health and Substance Use Disorder Treatment-Outpatient/Inpatient		
(13)	Home Health Services		

MMP Medicaid Benefits		
(a) In-Plan		**(b) Out-of-Plan**
(14)	Emergency Room Service and Emergency Transportation Services	
(15)	Nursing Home Care and Skilled Nursing Facility Care	
(16)	Services of Other Practitioners	
(17)	Podiatry Services	
(18)	Optometry Services	
(19)	Oral Health	
(20)	Hospice Services	
(21)	Durable Medical Equipment	
(22)	Environmental Modifications (Home Accessibility Adaptations)	
(23)	Special Medical Equipment (Minor Assistive Devices)	
(24)	Adult Day Health	
(25)	Nutrition Services	
(26)	Group/Individual Education Programs	
(27)	Interpreter Services	
(28)	Transplant Services	
(29)	HIV/AIDS Non-Medical Targeted Case Management	

MMP Medicaid Benefits		
(a) In-Plan		**(b) Out-of-Plan**
	for People Living with HIV/AIDS and those that are at High Risk for Acquiring HIV	
(30)	AIDS Medical Case Management	
(31)	Court-ordered Mental Health and Substance Abuse Services – Criminal Court	
(32)	Court-ordered Mental Health and Substance Abuse Treatment – Civil Court	
(33)	Telemedicine	
(34)	Preventive Services, including: Homemaker Personal Care Services Minor Environmental Modifications Physical Therapy Evaluation and Services Respite	
(35)	Long Term Services and Supports, including: Homemaker Meals on Wheels (Home Delivered Meals) Personal Emergency Response (PERS)	

MMP Medicaid Benefits		
(a) In-Plan		**(b) Out-of-Plan**
	Skilled Nursing Services (LPN Services) Community Transition Services Residential Supports Day Supports Supported Employment RIte @ Home (Supported Living Arrangements-Shared Living)* Private Duty Nursing Supports for Consumer Direction (Supports Facilitation) Self- Directed Goods and Services Financial Management Services (Fiscal Intermediary) Senior Companion (Adult Companion Services) Assisted Living Personal Care Assistance Services Respite Rehabilitation Services	
(36)	Opioid Treatment Provider Health Home	

1.8 Prescriptions: Generic Policy

A. For RHP and MMP enrolled members, Medicaid prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by the Medicaid agency, or the MCO acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below:

1. Availability of suitable within-class generic substitutes or out-of-class alternatives.

2. Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.

3. Relative disruptions in care that may be brought on by changing treatment from one drug to another.

4. Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.

5. Relative clinical advantages and disadvantages of drugs within a therapeutic class.

6. Cost differentials between brand and generic alternatives.

7. Drugs that are required under federal and State regulations.

8. Demonstrated medical necessity and lack of efficacy on a case by case basis.

B. For the MMP, the generic policy applies only to Medicaid covered drugs that are not part of the Medicare Part D formulary covered by the MMP. The MMP may cover brand name drugs as part of its Medicare Part D formulary, in accordance with Medicare Part D guidelines.

1.9 Non-Emergency Transportation Policy

Responsibility for transportation services rests first with the member. If the member's condition, place of residence, or the location of the medical provider does not permit the use of bus transportation, non-emergency transportation for the Medicaid enrollee may be arranged for by EOHHS, or its agent, in accordance with the provisions established in Part 20-00-2 of this Title.

1.10 Interpretation Services Policy

EOHHS will notify the health plan when it knows of members who do not speak English as a primary language who have either selected or been assigned to the plan. If more than fifty (50) members speak a single language, the RHP health plan must make available

general written materials, such as its member handbook, in that language. If more than five percent (5%) or fifty (50) members, whichever is less, speak a single language, the MMP must make available general written materials, such as its member handbook, in that language. Interpreter services, including sign language interpreters, are covered for any RHP or MMP member who speaks a non-English language as a primary language or who is deaf or hard of hearing.

1.11 Tracking, Follow-up, Outreach

Tracking, follow-up, and outreach services are provided by the health plan in association with an initial visit with the member's PCP, preventive visits and prenatal visits, referrals that result from preventive visits, and preventive dental visits. Outreach includes mail, phone, and home outreach, if necessary, for members who miss preventive and follow-up visits, and to resolve language, transportation, and other barriers to care.

1.12 Mainstreaming/Selective Contracting

The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of RHP and MMP. The MCO therefore must ensure that all of its network providers accept its members for treatment. The MCO also shall accept responsibility for ensuring that network providers do not intentionally segregate RHP and MMP members in any way from other persons receiving services. MCOs may develop selective contracting arrangements with certain providers for the purpose of cost containment but shall adhere to the access standards as defined in the MCO contracts.

1.13 Program of All-Inclusive Care for the Elderly (PACE)

1.13.1 Overview

PACE provides a managed plan of coordinated Medicare and Medicaid covered services from across the care continuum to certain beneficiaries age fifty-five (55) and older. The operations of PACE are bound by a three-way agreement between EOHHS, CMS, and the PACE provider to integrate the full range of Medicare (if eligible) and Medicaid services (primary care, acute care, specialty care, behavioral health care, and LTSS) for PACE participants.

1.13.2 EOHHS Responsibilities

EOHHS is responsible for the eligibility and enrollment functions set forth in § 1.13.4 of this Part, establishing PACE provider standards, and oversight and monitoring of all aspects of the PACE program.

1.13.3 PACE Provider Responsibilities

A. The PACE provider is responsible for:

1. Point of entry identification;

2. Submitting all necessary documentation for initial determinations and reevaluations of a level of need and referral to EOHHS for a determination of financial eligibility;

3. Verifying PACE enrollment prior to service delivery;

4. Verifying and collecting required beneficiary liability (cost-share amount);

5. Providing and coordinating all integrated services;

6. Reporting changes to the PACE-eligibility status of participants; and

7. Adhering to all PACE provider requirements as outlined in the PACE Program Agreement between EOHHS and CMS, and to all credentialing standards required by EOHHS including data submission.

1.13.4 PACE Participation Criteria

A. To qualify as a Medicaid-eligible PACE participant, an individual must:

1. Be fifty-five (55) years of age or older;

2. Meet the criteria for a high or the highest need for a nursing facility level of care in accordance with Part 50-00-5 of this Title; and

3. Meet all other financial and non-financial requirements for Medicaid LTSS such as, but not limited to, citizenship, residency, resources, income, and transfer of assets.

B. Medicaid-eligible PACE participants may be, but are not required to be, enrolled in Medicare.

1.13.5 PACE Disenrollment

A. Reasons for PACE Disenrollment – Reasons for disenrollment from PACE include but are not limited to:

1. Death;

2. Loss of Medicaid eligibility;

3. Eligibility error;

4. Placement in an out-of-state residential hospital;

5. Incarceration;

6. Change of state residence;

7. Loss of functional level of care; and

8. Voluntary opt-out to Medicaid FFS.

B. The PACE provider may also request in writing that a member be disenrolled on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members. In such instances, EOHHS will notify the PACE provider about its decision to approve or disapprove the disenrollment request within fifteen (15) days from the date EOHHS has received all information needed for a decision. Upon EOHHS approval of the disenrollment request, the PACE provider must, within three (3) business days, forward copies of a completed Disenrollment Request Form to EOHHS and to the Medicare enrollment agency (when appropriate). The PACE provider must also send written notification to the member that includes:

1. A statement that the PACE provider intends to disenroll the member;

2. The reason(s) for the intended disenrollment; and

3. A statement about the member's right to challenge the decision to disenroll and how to grieve or appeal such decision.

C. Disenrollment Requests Not Allowed. EOHHS does not permit disenrollment requests based on:

1. An adverse change in the member's health status;

2. The member's utilization of medical services; or

3. Uncooperative behavior resulting from the member's special needs.

D. Voluntary Disenrollment – PACE participants may voluntarily disenroll from PACE at any time. A voluntary disenrollment from PACE will become effective at midnight of the last day of the month in which the disenrollment is requested.

E. Disenrollment Process. Regardless of the reason for disenrollment, EOHHS is responsible for completing all disenrollment actions. Disenrollments requested by the PACE provider on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members are subject to EOHHS approval. Beneficiaries who are disenrolled from PACE but retain Medicaid eligibility will be enrolled in Medicaid fee-for-service and may subsequently choose or be enrolled in an alternative service delivery if they qualify. Beneficiaries have the right to appeal EOHHS's disenrollment action (see Part 10-05-2 of this Title).

F. Disenrollment Effective Date. Regardless of the reason for disenrollment, all disenrollments from PACE will become effective at midnight of the last day of the month in which the disenrollment is requested.

1.13.6 Disenrollment Appeal

If the member files a written appeal of the disenrollment within ten (10) days of the decision to disenroll, the disenrollment shall be delayed until the appeal is resolved.

1.13.7 Re-enrollment and Transition Out of PACE

All re-enrollments will be treated as new enrollments except when a participant re-enrolls within two months after losing Medicaid eligibility. In this situation, the participant's re-enrollment will not be treated as a new enrollment. The PACE provider shall assist participants whose enrollment ceased for any reason in obtaining necessary transitional care through appropriate referrals, by making medical records available to the participant's new service providers, and (if applicable), by working with EOHHS to reinstate the participant's benefits.

1.14 PACE Benefit Package

A. CMS and EOHHS approve PACE providers who are responsible for providing the full scope of Medicare (if eligible) and Medicaid State Plan and waiver services, including but not limited to:

1. Multidisciplinary assessment and treatment planning;
2. Case Management services;
3. Personal Care;
4. Homemaking;
5. Rehabilitation;
6. Social Work;
7. Transportation;
8. Nutritional Counseling;
9. Recreational Therapy;
10. Minor Home Modifications; and
11. Specialized Medical Equipment and Supplies.

B. The PACE program is voluntary for any eligible person, but if an individual selects this program, he/she must get all medical and support services through PACE. There are no benefits outside of the PACE program.

1.15 Federal Poverty Limits (FPLs) 2018

https://rules.sos.ri.gov/regulations/part/210-40-10-1

Chapter 40 - Medicaid for Elders and Adults with Disabilities

Subchapter 15 - Disabled Working Adults

Medicaid Code of Administrative Rules, Section 1373: Medicaid for Working People with Disabilities Program (210-RICR-40-15-1)

1.1 Scope and Applicability

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

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

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

1.2 Legal Authority

A. Federal Authorities:

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

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

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

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

1.3 Definitions

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

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

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

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

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

5. “Medicaid health coverage” means the full scope of essential health care services and supports authorized under the State’s Medicaid State Plan and/or Section 1115 demonstration waiver provided through an authorized Medicaid delivery system.

6. “Primary care essential benefits” means and includes non-LTSS Medicaid health coverage, and includes an array of acute, subacute, and specialty essential benefits, as identified under the Medicaid State Plan, provided by licensed health professionals and providers. These essential benefits include, but are not limited to: health promotion, disease prevention, health maintenance, counseling, patient education, various specialty services and diagnosis and treatment of acute and chronic medical and behavioral health illnesses and conditions in a variety of health care settings (such as office visits, inpatient, home care, day care).

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

1.4 SSI-Eligible Beneficiaries

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

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

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

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

b. Have been eligible for and received a regular SSI cash payment based on disability for a previous month within the current period of eligibility.

The prerequisite month does not necessarily have to be the immediate prior month.

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

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

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

c. Need Medicaid benefits to continue to work; and

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

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

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

(AA) Impairment-related work expenses;

(BB) Blind work expenses;

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

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

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

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

1. State -

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

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

2. Applicants/Beneficiaries -

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

(1) Consent – At the time a Medicaid beneficiary eligible on the basis of SSI no longer qualifies for continuing coverage under § 1619 (a) or (b), the State may request that he or she provide the State with consent to retrieve and review any information not currently on record pertaining to the eligibility factors subject to change through electronic data matches conducted through the State's eligibility system. Once such consent is provided, the Medicaid agency may retrieve and review such information when conducting all subsequent eligibility determinations and annual renewals.

(2) Duty to Report – Medicaid beneficiaries are required to report changes in eligibility factors to the Medicaid agency within ten (10) days from the date the change takes effect. Self-reports are permitted through the eligibility system consumer self-service portal as well as in person, via fax, or mail. Flexibility in reporting is allowed when a beneficiary changes work status and employers do not provide timely documentation of such changes.

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

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

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

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

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

b. Impairment-Related Work Expenses – Earned income used by a person with disabilities to pay impairment-related work expenses is disregarded. For the disregard to apply, the person must have a disability and be under age 65 or have been eligible for and received SSI based on disability for the month before reaching age 65. In addition, the following must be met:

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

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

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

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

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

b. Student Child Earned Income Exclusions (SEIE) – For a student under age 22 or a person who is blind or disabled and regularly attending school, a set amount of earned income per month up to a yearly maximum may be excluded. The federal government determines the monthly and maximum amounts based on variety of factors and adjusts the figures annually to reflect increases in the cost of living. The amount of the exclusion is set by the federal government and updated on an annual basis. The amount of the exclusion is located in Part 40-00-3.1.7 A (6) of this Title.

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

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

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

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

Part 40-05-2 of this Title on the Medically needy eligibility pathway for additional information.

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

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

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

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

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

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

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

1. Community Medicaid (Non-LTSS) – The two alternative eligibility pathways for MACC eligible working adults with disabilities who do not require or meet the level of care criteria for the full scope of Medicaid long-term services and

supports are: Community Medicaid EAD, including the Medically needy pathway as specified in Part 40-05-1.5 of this Title and above, and the Sherlock pathway, as set forth in § 1.8 of this Part. The SSI work-related income disregards indicated in §1.4 (B) (1) of this Part are applied and a disability determination by the MART or SSA is required;

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

1.7 Medicaid Long-term Services and Supports (LTSS)

1.7.1 Eligibility Determination Process

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

1.7.2 Service Plan

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

1.7.3 Cost of Care

A. In accordance with federal requirements, under the State's Medicaid State Plan and Section 1115 waiver, all LTSS Medicaid beneficiaries eligible based on the SSI method who can afford to do so must pay a portion of income toward the cost of their care. A beneficiary's liability for the cost of care is calculated in the post-eligibility treatment of income process in accordance with Part 50-00-8 of this Title and is based on gross

monthly income – earned and unearned – less certain deductions or "allowances." To encourage LTSS beneficiaries who have disabilities to work, there are special allowances which require the State to exclude some or all of the beneficiary's earned income when determining the amount available to be applied toward the cost of care.

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

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

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

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

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

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

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

1.7.4 LTSS Options and Responsibilities

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

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

2. LTSS Sherlock pathway – Working adults with disabilities seeking initial or continuing Medicaid LTSS who have countable assets (liquid resources and real property) above the resource eligibility limits of $4,000 for a single person and $6,000 for a couple may qualify for coverage through the Sherlock pathway. Income, whether earned or unearned, does not affect Medicaid LTSS eligibility unless the total exceeds the cost of care at the private pay rate, in accordance with § 50-05-2.5 of this Title. As indicated in § 1.8 of this Part below, to qualify for the LTSS Sherlock pathway, a formal disability determination must be made by the MART or the SSA and the SSI for calculating countable income and resources applies, including the applicable work-related disregards.

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

1.8 The Sherlock Plan

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

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

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

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

2. Medicaid LTSS coverage including integrated employment supports.

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

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

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

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

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

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

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

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

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

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

1.8.1 Access to Employer-Based Health Insurance

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

1.8.2 Types of Cost Sharing

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

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

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

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

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

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

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

1.8.3 Cost-Share Collection Methods

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

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

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

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

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

1.8.4 Non-Payment Sherlock Cost Share

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

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

1.8.5 Loss of Employment or Eligibility

A. A Sherlock beneficiary who loses employment may retain eligibility for up to four (4) months by continuing to pay the applicable cost share, whether a premium or beneficiary liability payment. If the person is still unemployed at the end of the four (4) month period, Sherlock eligibility is terminated. Prior to taking this action, the State evaluates the Sherlock beneficiary for all other forms of Medicaid eligibility as well as for coverage for a commercial plan through HSRI, the State's health insurance marketplace.

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

1.8.6 Available Services

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

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

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 00 - Long-Term Services

Medicaid Long-Term Services and Supports Overview and Eligibility Pathways (210-RICR-50-00-1)

1.1 Overview

The provisions set forth herein pertain to the scope of Medicaid long-term services and supports (LTSS) and the various pathways for initial and continuing eligibility.

1.2 Legal Authority

A. This Chapter of rules related to Medicaid LTSS 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, 1115, 1902, 1903, 1905, 1915; 1396k; 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. Additionally, legal authority related to LTSS is derived from R.I. Gen. Laws, Chapter 40-8 and §§ 40-8.6 to 40-8.13.

1.3 Definitions

A. For the purposes of LTSS Medicaid, the following definitions apply:

1. “Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals" or "BHDDH” means the state agency established under the provisions of R.I. Gen. Laws Chapter 40.1-1 whose duty it is to serve as the State’s mental health authority and establish and promulgate the overall plans, policies, objectives, and priorities for State programs for adults with intellectual and developmental disabilities as well mental illness and substance abuse education, prevention and treatment.

2. “Department of Human Services" or "DHS” means the State agency established under the provisions of R.I. Gen. Laws Chapter 40-1 that is empowered to administer certain human services. The DHS has been delegated the authority through an interagency service agreement with the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, to determine

Medicaid eligibility in accordance with applicable State and federal laws, rules and regulations.

3. “Developmental disability” means, for the purposes of the RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, a condition that affects a person, eighteen (18) years or older, who is either an intellectually developmentally disabled adult or a person with a severe, chronic disability that:

a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;

b. Manifests before the person attains age twenty-two (22);

c. Is likely to continue indefinitely;

d. Results in substantial functional limitations in three (3) or more of the following areas of major life activity:

(1) Personal care

(2) Communication

(3) Mobility

(4) Learning

(5) Self-direction

(6) Capacity for independent living

(7) Economic self-sufficiency; and

(8) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services which are life-long or of extended duration and are individually planned and coordinated.

4. "Eligibility date" means the first day of the month in which a person is eligible for Medicaid LTSS. It is based on the month the application or, for existing beneficiaries, the request for LTSS is made and is otherwise unrelated to the date a person entered an institution or began receiving LTSS, regardless of payer. The eligibility date does not include periods of retroactive eligibility.

5. “Executive Office of Health and Human Services" or "EOHHS” means the state agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 within the executive branch of state government which serves as the principal agency for managing the Departments of Children, Youth, and Families

(DCYF); Health (RIDOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).

6. “Financial eligibility” means the set of factors used to determine whether a person is entitled to receive services based upon income and/or resource requirements, as well as limitations related to the transfer of assets, which includes both liquid resources and real property, prior to the application for Medicaid LTSS.

7. “Functional disability” means any long-term limitation resulting from an illness, health condition, or impairment that affects a person’s ability to perform certain activities of daily living without substantial assistance or supervision.

8. “Home and Community-Based Services" or "HCBS” means any Medicaid LTSS State Plan or Section 1115 waiver-authorized services available to beneficiaries at home or in a community-based setting.

9. “Institution” or "Health institution" means a State-licensed health facility that provides health and/or social services and supports on an in-patient basis. For the purposes of this rule, the term means long-term care hospitals and treatment facilities (LTH), intermediate care facilities for persons with intellectual disabilities (ICF/ID), and nursing facilities (NF).

10. “Integrated Health Care Coverage Groups” or "IHCC" means any Medicaid coverage group consisting of adults who are eligible based on receipt of Supplemental Security Income (SSI), SSI protected status, the SSI income methodology and a related characteristic (age or disability), or as a result of participation in another federal or State program, such as the Breast and Cervical Cancer Program. This group includes beneficiaries eligible for community Medicaid (non-long-term care), Medicaid-funded LTSS and the Medicare Premium Payment Program (MPPP).

11. “Integrated Health and Human Services Eligibility System" or "IES” means the state's eligibility system that enables applicants, through a single application, to be considered for multiple health and human service programs simultaneously.

12. “Intermediate Care Facility for Persons with Intellectual/Developmental Disabilities" or "ICF/ID” means a State-licensed health care facility that provides long-term services and supports to persons with intellectual /developmental disabilities.

13. “Katie Beckett eligibility” means an eligibility category that allows certain children under age 19 who have long-term disabilities or complex medical needs who require an institutional level of care to obtain the Medicaid long-term services they need at home. With Katie Beckett eligibility, only the child’s income and resources are considered when determining eligibility.

14. “Long-term services and supports" or "LTSS" means a spectrum of services covered by the Medicaid program for persons with clinical and functional impairments and/or chronic illness or diseases that require the level of care typically provided in a health care institution. Medicaid LTSS includes skilled or custodial nursing facility care, therapeutic day services, and personal care as well as various home and community-based services. Medicaid beneficiaries eligible for LTSS are also provided with primary care essential benefits. The scope of these services and supports and the choice of settings is determined by a comprehensive assessment of each person's unique care needs.

15. “LTSS living arrangement” means the institutional or home or community-based setting where a Medicaid LTSS beneficiary resides while receiving Medicaid LTSS.

16. “LTSS specialist” means a State agency representative responsible for conducting assessments, determining eligibility for LTSS, authorizing services, and/or providing assistance to people in navigating the Medicaid LTSS system.

17. “Medicaid Affordable Care Coverage Groups” or "MACC" means a classification of persons eligible to receive Medicaid who are subject to the Modified Adjusted Gross Income or "MAGI" standard for determining income eligibility as outlined in the Medicaid Code of Administrative Rules, "Health Coverage for Children, Families, and Adults" (See Part 30-00-5 of this Title).

18. “MAGI standard” means the method for evaluating Medicaid income eligibility using the modified adjusted gross income (MAGI) standard established under the ACA. Persons who are or would be income-eligible for the ACA expansion for adults may obtain Medicaid LTSS if they meet the applicable clinical/functional eligibility criteria, are under age sixty-five (65), and are not eligible for or enrolled in Medicare.

19. "Medicaid Single State Agency" means the state agency authorized under state law, Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) and the Medicaid State Plan as the entity legally responsible for the program / fiscal management and administration of the Medicaid program. The EOHHS is the designated single state agency in Rhode Island.

20. “Needs-based criteria” means the basis for determining clinical/functional eligibility for Medicaid LTSS. The LTSS needs-based criteria encompass medical, social, functional, and behavioral factors, and the availability of family support and financial resources.

21. “Preadmission Screening and Resident Review" or "PASRR” means the process required by federal law that evaluates and ensures individuals who have a serious mental illness (SMI) and/or intellectual disability are not inappropriately placed in nursing facilities for long-term care. PASRR requires that those

applicants for a Medicaid-certified nursing facility are evaluated for appropriateness.

22. “Primary care essential benefits” means non-LTSS Medicaid health coverage, and includes an array of acute, subacute, and specialty essential benefits, as identified under the Medicaid State Plan, provided by licensed health professionals. These essential benefits include, but are not limited to: health promotion, disease prevention, health maintenance, counseling, patient education, various specialty services and diagnosis and treatment of acute and chronic medical and behavioral health illnesses and conditions in a variety of health care settings such as office visits, inpatient, home care, and day care.

1.4 Types of LTSS

A. Under the terms of Title XIX of the U.S. Social Security Act of 1964, Medicaid LTSS in an institutional-setting is a State Plan service available to all otherwise eligible Medicaid beneficiaries and new applicants, providing they meet certain eligibility factors.

B. “Institution” is the term used in Title XIX to refer to a hospital (H), an intermediate care facility for persons with intellectual/developmental disabilities (ICF/ID), and a nursing facility (NF). These institutions are licensed in Rhode Island by the Department of Health (RIDOH) as health care facilities under Chapter 23-17 of the R.I. Gen. Laws. Although the term "institution" is not accurate in a licensure sense, under federal regulations at 42 C.F.R. § 440.40, the eligibility criteria for Medicaid LTSS remain tied to these institutional settings and vary in accordance with types of services each typically provides and the needs of the population(s) they serve. As these services are now also available to beneficiaries in a home and community-based setting, the Medicaid LTSS rules apply across settings, as follows:

1. Medicaid LTSS in Health Care Institutions - Persons who meet the applicable eligibility requirements may access LTSS in the following State-licensed health care institutions/facilities -

a. Nursing Facilities (NF). A person is eligible to access Medicaid LTSS in a NF when it is determined, based on a comprehensive assessment, that he or she has the highest need for a NF level of care.

b. Intermediate Care Facility for persons with Intellectual/Developmental Disabilities (ICF/ID). To qualify, a person must meet the applicable statutory standards set forth in § 40.1-22-6 pertaining to developmental disabilities and:

(1) have the level of need for LTSS typically provided in an ICF-ID; or

(2) would require an ICF/ID level of care if were not for LTSS provided in a home or community based setting. As the State's

Section 1115 waiver provides the authority for the home and community-based LTSS provided to members of this population with developmental disabilities, the BHDDH is required to provide services in the least restrictive setting appropriate to a person's level of care needs.

c. Long-term Hospital (LTH) - A person must meet the needs-based criteria for long-term services in a hospital setting established by BHDDH and/or the EOHHS. Medicaid LTSS may also be available to children in State custody or with special health care needs receiving services in residential treatment facilities and hospitals if they meet the applicable level of care requirements.

2. Medicaid Home and Community-based (HCBS) LTSS - The State's Section 1115 demonstration waiver authorizes Medicaid LTSS when provided in a home and offers an array of community-based settings as an alternative to care in one of the three principal covered health care institutions (NF, ICF/ID, or LTH). Access to these services enables beneficiaries to optimize their health and retain their independence while delaying or diverting the need for care in a more restrictive health care institutional setting.

a. Scope of HCBS Coverage. Medicaid HCBS includes both core and specialized services and supports authorized under the State Plan or Section 1115 demonstration that address each individual beneficiary's unique long-term functional and clinical needs. The array of HCBS may vary depending on the beneficiary's needs and the institutional level of care required.

b. Limitations. Room and board are NOT covered for HCBS by Medicaid.

1.5 Applicability

The provisions set forth herein apply to any person seeking Medicaid LTSS coverage, including those who are uninsured, receiving non-LTSS Medicaid under Part 3 of Chapter 40 of this Title or MCAR 1305, "Eligibility Requirements", or have third-party forms of coverage through Medicare or a commercial insurer.

1.6 Scope of LTSS Coverage

A. Upon being determined eligible for Medicaid LTSS, a beneficiary is entitled to Medicaid State Plan and Section 1115 waiver services across the care continuum. Subchapters 05 and 10 of this Chapter identify the LTSS covered services and the various Medicaid LTSS programs that serve beneficiaries with specific types of health needs, including the following:

1. Primary care essential benefits. All LTSS Medicaid beneficiaries are entitled to receive the primary care essential health benefits available to beneficiaries in the

MACC and IHCC groups, covered under the Medicaid State Plan and Section 1115 demonstration waiver, including primary and preventive care as well as acute and subacute services. If a beneficiary has third-party insurance, such as Medicare or commercial insurance that does not provide the full scope of Medicaid benefits, Medicaid provides wrap-around coverage for any Medicaid services that are unavailable.

2. Institutional and home and community-based care. Medicaid LTSS beneficiaries are eligible for the full scope of LTSS covered by the Medicaid State Plan and Section 1115 waiver. As the State uses needs-based criteria to determine the scope of services a beneficiary is authorized to receive, Medicaid LTSS coverage varies along with a beneficiary's functional capacity and acuity needs, social environment, access to family and other third party supports, and personal choices. The range of Medicaid LTSS extends from 24/7 comprehensive care in a health institution to a limited package of services in a community-based setting, to one, a few, or a bundle of home and community core and ancillary services in the home.

B. Medicaid beneficiaries who are receiving primary care essential benefits through a managed care plan or fee-for-service through a MACC group MAGI pathway pursuant to Part 30-00-2 of this Title (ACA Expansion Adults) or a IHCC group SSI (Supplemental Security Income or SSI eligible and SSI-protected status and Elders and Adults with Disabilities or EAD) pathway in accordance with Part 40-00-1 of this Title may be eligible for Medicaid LTSS preventive (see § 40-05-1.8 of this Title) or full benefits if they meet certain clinical/functional and financial eligibility criteria. The State uses information known about the beneficiary when determining eligibility for LTSS for current Medicaid beneficiaries to the full extent feasible. The additional information required, as out-lined below, may be provided by completing the applicable sections of the DHS-2 form, or designated supplemental form, or by updating an on-line account as appropriate:

Basis of Eligibility	Supplemental Information Required from Existing Beneficiaries Seeking LTSS			
	Preventive **LTSS Clinical/function** **(See Part 40-05-1 of this Title)**	**Functional/clinical** **Level of Need (See Part 5 of this Subchapter)**	**Financial Eligibility - Allocation of resources and transfer of assets - Part 40-00-3 of this Title and Part 6 of this Subchapter)**	**Post-eligibility Treatment of Income (See Part 8 of this Subchapter)**
1.SSI	Documentation from health provider	Documentation from health provider	Limited to current information on spouse and dependents as related to spousal impoverishment and transfer of assets	Applies - information related to allowances including income and expenses of spouse and dependents
2. EAD	Documentation from health provider	Documentation from health provider	Limited to 60 months pre-application of information on spouse and dependents as related to spousal impoverishment and transfer of assets	Applies - information related to allowances income and expenses of spouse and dependents
3. ACA Expansion Adults	Not applicable	Documentation from health provider	Limited 60 months of pre-application information on resources of self, spouse and dependents as related to transfer of assets only	Not applicable

1.7 Qualifying for Medicaid LTSS

A. Under Title XIX, the federal Medicaid law, an applicant for LTSS must be either a current beneficiary or possess an income, clinical/functional, or age-related characteristic related to a MAGI eligible or SSI population AND have an established need to qualify to apply. With the enactment of the federal Affordable Care Act of 2010, federal law requires that Medicare, commercial health insurers, and group health plans provide as part of the primary care essential benefit package up to thirty (30) days of subacute and rehabilitative care for persons who have had an acute care incident requiring services in a health institution. Medicaid is also required to provide this benefit. Both existing beneficiaries and new applicants must have established a continuing need for LTSS --

that is, for an institutional level of care -- to qualify for Medicaid LTSS once the thirty (30) days of essential benefit coverage is exhausted. This need in previous RI Medicaid rules was referred to as "considered institutionalized" for the purposes of determining Medicaid LTSS eligibility as indicated below:

1. Existing beneficiaries - Under the Medicaid State Plan, all Medicaid beneficiaries are eligible for up to thirty (30) days of LTSS coverage in addition to the required thirty-day essential benefit period of acute and subacute care in a health care institution as part of their non-LTSS primary essential benefit coverage. A separate determination of eligibility or change in service delivery is not required for this period of coverage. Therefore, an existing beneficiary may qualify to apply for Medicaid LTSS without a change in eligibility or service delivery options if they have received the required period of continuous coverage is provided in this manner or, if seeking LTSS in the home and community-based setting, they require or are receiving at least one Medicaid covered LTSS benefit to address a functional need that otherwise would require care in an institutional setting. The Medicaid MCOs and DHS eligibility specialists are available to provide assistance to existing beneficiaries during this period.

2. New applicants - New Applicants are considered to have such a need if they have met one of the following:

a. Received the level of services typically provided in a NF, ICF-ID, or LTH setting for at least thirty (30) consecutive days and are expected to have a continued need for such services or have:

(1) Obtained acute care services in a hospital or similar health facility for at least thirty (30) consecutive days and are seeking LTSS;

(2) Received Medicaid preventive level services while residing at home or in a community-based care setting for at least thirty (30) consecutive days;

(3) Been determined to have needs that require the level of services typically provided in a health care institution for at least thirty (30) consecutive days or would require such services were those in the home and community-based setting not provided.

b. Received or required at least one Medicaid covered LTSS benefit at home or in a community-based setting to address a functional/clinical need that would otherwise necessitate the type of LTSS typically provided in a health institution.

1.8 Eligibility Determination Process

A. There is a multiphase process for determining eligibility and authorization for Medicaid LTSS that includes the following steps:

1. Information, Referral, Options Counseling - Prior to initiating the application process and/or at any step during the eligibility determination sequence, applicants and/or their family members or authorized representatives may seek information, referral and/or options counseling to assist them in navigating the LTSS system. Part 4 of this Subchapter sets forth role of this service.

2. Person-centered Planning -- Upon making application for LTSS, the person-centered planning process must begin for anyone seeking HCBS. The process is available, at the applicant's option, for LTSS in a health care institution as well. Person-centered planning is an individualized approach to planning that places the applicant at the center of decision-making thereby enabling him or her to direct his/her own services and supports in accordance with his/her own desires, goals and preferences, with impartial assistance and supported decision-making when helpful. Accordingly, the person-centered planning is an on-going process that continues through the eligibility determination process through to the authorization of services and thereafter. In accordance with 45 C.F.R. § 441.301(c)(1), the State must ensure that throughout this process, the applicant has sufficient and necessary information in a form he/she can understand to make informed choices and direct the planning process to the maximum extent possible. See Part 4 of this Subchapter for specific provisions.

3. Eligibility Determination Factors - To gain access to LTSS, the information provided by applicants is evaluated across the eligibility factors identified below, though not necessarily in a specific order:

a. General eligibility factors. All persons seeking initial or continuing Medicaid LTSS must meet the general requirements for the program related to residency, citizenship and immigration status, and social security numbers and the like. The application form must be completed and signed along with the authorizations necessary to conduct electronic data matches to verify income and resources; and to request personal health information to assess and review clinical/functional level of need. General eligibility factors for MACC MAGI-based LTSS eligibility are located in § 30-00-1.5(C) of this Title and for SSI-based LTSS eligibility in Part 5 of this Subchapter. Existing beneficiaries seeking LTSS must only update general eligibility information if there have been changes since the point of their last renewal.

b. Clinical/functional eligibility factors. An assessment of clinical and functional needs serves as the basis for a level of care determination and is conducted for all persons seeking Medicaid LTSS, without regard to eligibility pathway. This assessment is based on needs-based criteria that evaluate clinical, functional, social and behavioral needs as well as environmental factors. A Medicaid Assessment and Review Team

(MART) determination of disability status is not required unless the applicant is seeking LTSS coverage while working through the Sherlock Plan or unless the applicant has been deemed to have a disability by the Social Security Administration. The responsibilities for assessing need vary for each institutional level of care as follows:

(1) Nursing Facility. The State established clinical and functional disability criteria under the Section 1115 waiver which assess the scope of a beneficiary's need for a NF level of care. The EOHHS is responsible for assessing the level of need of persons seeking Medicaid coverage of LTSS typically provided in a NF and long-term hospital care, including home and community-based alternatives. As indicated in Part 5 of this Subchapter, the scope of a person's clinical/functional need for a NF level of care (high or highest) affects the type of LTSS available to the person and thus the choice of setting (institutional and/or HCBS).

(2) Intermediate care facilities for persons with intellectual disabilities. The BHDDH uses needs-based criteria to evaluate clinical/functional eligibility for the ICF/ID level of care that incorporate the requirements set forth in State law (R.I. Gen. Laws § 40.1-22-6), the scope of services and supports required, and the impact of familial, social, and environmental factors that affect the choice of setting.

(3) Long-term Hospital Care. Each agency serving beneficiaries who may require Medicaid LTSS in a hospital setting is authorized under the State's 1115 waiver to tailor the clinical/functional criteria to meet their population's general and unique needs within the parameters of applicable federal regulations and laws. This applies to persons seeking services through the EOHHS Habilitation Program that were authorized prior to establishment of the Section 1115 demonstration in 2009 under the State's § 1915(c) Habilitation Waiver and the various programs administered by the BHDDH. EOHHS determines clinical/functional eligibility for applicants seeking an LTH level of care through the Medicaid Habilitation program and certain persons referred by the BHDDH for admission to the State's Eleanor Slater Hospital.

(4) Children with Special Health Care Needs. Children with disabilities and/or serious chronic and disabling conditions may require a NF, ICF/ID or LTH level of care at home or in an institutional-setting. The process for assessing level of need for children who are eligible based on the MAGI, SSI or custody of the State's Department of Children, Youth and Families (DCYF) is conducted by multiple entities under the auspices of the early,

periodic, screening, detection and treatment (EPSDT) in Part 30-00-1 of this Title. The designated unit of EOHHS determines clinical/functional eligibility for children who do not qualify for coverage through one of these pathways and are seeking coverage of LTSS in a home setting in accordance with the provisions located in Part 10-3 of this Chapter. Continuing eligibility for current beneficiaries is based on the method used to determine initial eligibility and, if no basis for coverage is found, across the remaining pathways.

c. Financial Eligibility Factors. LTSS eligibility specialists in the Department of Human Services (DHS) are responsible for determining financial eligibility through the IES and related systems. The financial requirements pertain to an array of factors including the calculation of countable income and resources using the MAGI or SSI method and the allocation of resources and transfer of asset requirements that are unique to the determination of LTSS eligibility. Both of the following apply to new and existing beneficiaries seeking LTSS without regard to basis of eligibility and are explained in greater detail in Part 6 of this Subchapter.

(1) Allocation of resources with spouses/dependents. The evaluation and allocation of resources at the point the need for LTSS is established and/or at the time of application is required for LTSS applicants who have spouses. This process, referred to as the Community (Non-LTSS) Spouse Resource Allowance (SRA), allocates the joint resources of couples in accordance with federal standards to ensure a sufficient amount is protected for the non-LTSS spouse's needs -- that is, unavailable to pay for the costs of care for the LTSS applicant/beneficiary. The allocation of resources at this state of the eligibility process is distinct from that which occurs when determining the amount of income a beneficiary must pay toward the cost of care in the “post-eligibility” treatment of income. LTSS MAGI beneficiaries are subject to allocation of resource requirements but are exempt from the post-eligibility treatment process.

(2) Transfer of assets. The determination of financial eligibility for Medicaid LTSS requires that the State review whether an applicant made a "disqualifying" transfer of assets - liquid resources and real property -- in the sixty (60) month period before the need for LTSS was established. A transfer is deemed to be disqualifying if the asset was conveyed for less than fair market value. Under federal law, such a transfer is presumed to have been made to reduce assets for the expressed purpose of gaining Medicaid LTSS eligibility. The State is required to impose a penalty period, during which Medicaid coverage for LTSS is unavailable, that is equal to

the amount of the disqualifying transfer divided by the average cost of care at the private pay rate.

B. Once eligibility has been determined, payment for Medicaid LTSS becomes available only after the following inter-related steps are completed:

1. Service Plan -- Development of a service plan ensures that a beneficiary is or will be able to attain the full scope of services required to meet his or her needs in the choice of LTSS living arrangement. Towards this end, LTSS specialists from across the EOHHS agencies and their community partners and contractual agents consider the results of the clinical/functional needs-based assessment, more intensive evaluations, as appropriate, and/or the consensus decisions made in the person-centered planning process for HCBS or the results of the PASRR for nursing facility care to help ensure that every beneficiary receives the right services, at the right time, and in the most appropriate setting.

2. Post-Eligibility Treatment of Income (PETI) -- Under the State's Section 1115 waiver, all non-MAGI eligible LTSS beneficiaries are subject to the PETI process. PETI is the basis for calculating a beneficiary's liability to pay toward the cost of care. During this process, income is evaluated a second time, federal spousal impoverishment requirements are applied, if appropriate, and additional deductions from income are taken for personal needs, non-covered health care costs like insurance premiums, and other allowable expenses. PETI varies somewhat depending on the type of Medicaid LTSS -- in a health institution or HCBS -- selected by a beneficiary and the requirements of his/her service plan. Accordingly, the development of the service plan and the beneficiary's health care priorities and preferences established in the person-centered planning process are important factors that must be considered when calculating beneficiary liability. The PETI process is set forth in detail in Part 8 of this Subchapter.

3. Authorization of Payment for LTSS - Authorization of Medicaid LTSS is required before a payment is made for coverage provided to a beneficiary. This process entails a complex set of transactions in which information about the scope of services approved and/or utilized and the beneficiary's liability are transmitted from the IES to the State's Medicaid claims system (Medicaid Management Information System or "MMIS"). Once these transactions are completed, payment is authorized to an LTSS provider dating back to the eligibility date -- the first day of the month in which the application was filed -- and prospectively unless retroactive eligibility has been approved.

1.9 Eligibility Pathways

A. The eligibility pathways available to persons seeking Medicaid LTSS have different requirements all of which are automatically taken into account when application information is processed. As indicated below, the process for determining eligibility and the sequence may vary for members of a particular population depending on the pathways available.

1. SSI and SSI-related Groups - SSI recipients and members of certain SSI-related groups are automatically eligibility for Medicaid based on a determination by SSA as indicated in Part 40-00-3 of this Title. Federal regulations at 42 C.F.R. § 435.603(j) specifically exclude Medicaid determinations of eligibility for members of this group, including for LTSS, using the MAGI standard except in instances in which an SSI recipient no longer meets disability criteria and loses cash assistance on this basis. Special provisions also apply to Medicaid LTSS beneficiaries who are receiving SSI and are expected to need LTSS coverage for ninety (90) days or less. Accordingly, access to LTSS proceeds as follows:

a. Eligibility Criteria. Medicaid beneficiaries who are SSI-eligible and need LTSS are subject to the clinical/functional eligibility factors required for an institutional level of care set forth in Part 05-1 of this Chapter as well as the financial eligibility requirements related to the transfer of assets. The resource limit is set at $2,000.

b. Special Conditions. Re-evaluation of income and resources is not required unless current eligibility is based on different Medicaid group size (couple v. individual) or there is a change in income or resources resulting from need for or use of LTSS. In addition:

(1) SSI recipients who have § 1619(b) status, as indicated in § 40-05-1.5.4 of this Title, remain eligible for two (2) months of continuing SSI cash assistance if admitted to an LTH, such as Eleanor Slater Hospital or an equivalent HCBS setting; and

(2) SSI recipients who obtain Medicaid LTSS for a period not expected to exceed ninety (90) days may continue to receive SSI cash assistance during this time to maintain a community residence. Such income is excluded in the financial eligibility determination sequence, including the post-eligibility treatment of income.

c. Determination Process. SSI recipients are not subject to a MAGI determination and a re-evaluation of income/resource eligibility using the SSI method is not required when applying for LTSS. Although a review of functional/clinical eligibility is conducted, a full assessment of level of care needs may be waived for certain populations based on their type of disability as indicated in Part 5 of this Subchapter. All other steps in the eligibility determination process apply to the extent that the special rules applicable to the treatment of SSI income allow, as indicated in Part 40-00-3 of this Title.

d. Retroactive Coverage. Retroactive coverage is available for any allowable non-Medicaid covered LTSS expenses in the ninety (90) day period prior to the eligibility date in circumstances in which the applicant for LTSS was not enrolled in Medicaid at that time.

2. Adults 19 to 64 - All persons seeking initial or continuing eligibility for Medicaid LTSS in this age group are evaluated across several pathways unless they are currently eligible for Medicaid.

a. Eligibility Criteria. Applicants are subject to the general and functional/clinical eligibility requirements. Not all financial eligibility factors such as resource limits apply, as indicated. The financial eligibility requirements vary across pathways; if a beneficiary is determined ineligible in the current category (existing beneficiaries) or a pathway of choice (new applicants), the IES automatically evaluates whether eligibility through another pathway exists up to and including the medically needy pathway. The process generally proceeds as follows:

(1) MACC Group for MAGI-eligible Adults: Income limit -133% of the FPL; No resource limit.

(2) IHCC non-SSI eligible Adults with Disabilities in Community Medicaid: Income limit - 100% of the FPL; Resource Limit - $4,000. Applies to new applicants and existing beneficiaries.

(3) Special Income/HCBS: Income limit - 300% of the SSI standard; Resource Limit - $4,000. New applicants only.

(4) Medically Needy: Income limit - Cost of Care; Resource Limit - $4,000. New applicants only

b. Special Conditions. Several eligibility pathways have special conditions that target or exclude certain populations:

(1) MACC Group for MAGI-eligible Adults: Pathway is closed to persons who are 65 and older or who are eligible for or enrolled in Medicare. In addition to the exemption from a resource limit, PETI rules do not apply and, as a result, beneficiaries in this group do not have to pay a portion of income toward the cost of care. Spousal impoverishment protections, guaranteed through the SSI method, are also unavailable through this pathway.

(2) IHCC non-SSI adults with disabilities in Community Medicaid: Current beneficiaries may request to be assessed for an LTSS level of care and provide only the information related to financial eligibility factors to evaluate the transfer of assets, the allocation of resources between spouses/dependents, and beneficiary liability in accordance with Part 8 of this Subchapter. Existing beneficiaries seeking Medicaid LTSS under the Sherlock Plan must apply pursuant to the requirements set forth in Part 40-15-1 of this Title.

(3) Special Income: Pathway for new applicants with income above the Community Medicaid limit (up to 300 percent of the SSI benefit rate) and adults with disabilities in the IHCC medically needy group who are seeking care in a health institution such as a hospital or nursing facility.

(4) HCBS: Reserved for persons seeking Medicaid LTSS in the HCBS setting who would, absent these services, have the "high" or "highest" need for an institutional level of care. Generally, these are new applicants for Medicaid.

(5) Medically Needy: Countable income must be below the average cost of care in the applicable institutional setting, as set forth in Part 40-05-2 of this Title. Special income deductions also apply.

c. Determination Process. The principal distinction in the determination process aside from the difference in eligibility criteria is the method for evaluating income - MAGI v. SSI - as indicated below:

(1) New Applicants for Medicaid -- When applying for Medicaid LTSS, all new applicants who are under age sixty-five (65) and are neither enrolled in or eligible for Medicare are evaluated first to determine whether eligibility using the MAGI method for the MACC group for adults exists. Transfer of asset requirements are applied and an applicant must provide any information about liquid resources and real property necessary to complete that step in the eligibility process. If a new applicant under age 65 is found ineligible for the MAGI-based MACC group coverage, or is requesting retroactive coverage, the SSI method is used to determine financial eligibility and all steps in the LTSS determination process, including PETI apply.

(2) Current Medicaid Beneficiaries -- Current Medicaid beneficiaries who are seeking LTSS remain within the eligibility category that serves as the basis for their existing eligibility and are only referred as appropriate if LTSS eligibility in this category would be denied due to the supplemental information provided when seeking LTSS. Adults with disabilities who are receiving non-LTSS Community Medicaid under Chapter 40 of this Title are referred for a determination of clinical/functional eligibility, in the same manner as those who are SSI-eligible, while the required financial eligibility factors unique to LTSS are reviewed. All beneficiaries can initiate the LTSS eligibility determination by contacting a DHS LTSS eligibility specialist and completing the applicable sections of the integrated health and human services

application form, or an alternative form designated for this purpose, or updating their accounts in the IES Consumer Portal.

d. Retroactive Coverage. Retroactive coverage for up to ninety (90) days is available for LTSS applicants in this population who are determined eligible using the SSI method. Under the terms of the State's Section 1115 demonstration waiver, all MAGI-eligible MACC groups, including the ACA expansion adults, do not have access to retroactive coverage unless eligible as a pregnant woman under the terms and conditions of the State's Section 1115 waiver.

3. Elders 65 and older - The eligibility pathways for persons sixty-five (65) years of age and older vary somewhat when compared to those available for persons between 19 and 64 as specified above. The chief distinction is that members of this population are not evaluated for MAGI-based eligibility even if they are the parents/caretakers of a Medicaid eligible child. Differences in criteria by pathway are as follows:

a. Eligibility Criteria. All persons seeking Medicaid LTSS are evaluated using the SSI method through to the authorization of services; MAGI-based eligibility is not permitted under applicable federal law. Although the income requirements vary, the resource limit is $4,000 for an individual applicant across pathways:

(1) IHCC non-SSI eligible elders in Community Medicaid: Income limit - 100% of the FPL; Resource Limit - $4,000.

(2) Special Income/HCBS: Income limit - 300% of the SSI standard; Resource Limit - $4,000

(3) Medically Needy: Income limit - Cost of Care; Resource Limit - $4,000

b. Special Conditions. The special conditions for adults with disabilities whose eligibility is determined using the SSI method also apply to elders.

c. Determination Process. The principal distinction in the determination process for members of this population is also a function of whether a person is a new applicant or current Medicaid beneficiary.

(1) New Applicants for Medicaid -- When applying for Medicaid LTSS, all new applicants who are sixty-five (65) year of age and older are subject to a full financial eligibility review using the SSI method as well a determination of clinical/functional eligibility and all the steps in the LTSS determination process, including PETI apply.

(2) Current Medicaid Beneficiaries -- Current Medicaid beneficiaries who are sixty-five (65) and older and eligible and receiving non-LTSS MACC Medicaid as a parent/caretaker under Chapter 30 of this Title are referred for both a full financial eligibility review using the SSI method, which requires that they provide additional information related to their own and joint spousal resources, and functional/clinical eligibility review. Current beneficiaries eligible for non-LTSS Community Medicaid under Chapter 40 of this Title are referred for a determination of clinical/functional eligibility, in the same manner as those who are SSI-eligible, while the required financial eligibility factors unique to LTSS are reviewed. All beneficiaries can initiate the LTSS eligibility determination by contacting a DHS LTSS eligibility specialist and completing the applicable sections of the integrated health and human services application form, or an alternative form designated for this purpose, or updating their accounts in the IES Consumer Portal.

d. Retroactive Coverage. Retroactive coverage is available for a period of up to ninety (90) day for LTSS applicants evaluated on the basis of the SSI method. Accordingly, all elders are eligible for retroactive coverage.

4. Children up to Age 19 - Children requiring LTSS are generally evaluated for MACC group eligibility and provided the services and supports they need under the authorities included in the Medicaid State Plan without requiring a separate determination of eligibility. As indicated in Part 10-3 of this Chapter, there is also a separate eligibility pathway known as Katie Beckett (KB), which was established by Congress for children with serious illnesses and/or disabilities who are receiving care at home and, as a result, would otherwise be ineligible for Medicaid. These children would most likely be eligible if they were receiving care in an institution. The KB pathway, which is named after the young woman who inspired its creation by Congress, applies the SSI institutional rules to provide Medicaid coverage available to these otherwise ineligible children by deeming their parents' income as unavailable to them. Accordingly, children eligible through the KB pathway receive the full scope of Medicaid State Plan and Section 1115 waiver services, including Early, Periodic, Screening, Detection and Treatment (EPSDT), provided to children with severe chronic diseases and/or disabling impairments who qualify in the MACC group pathway based on MAGI pursuant to Part 10-3 of this Chapter. The eligibility pathways differ as follows:

a. Eligibility Criteria. All children seeking initial or continuing eligibility for Medicaid LTSS coverage must meet the general requirements for eligibility. Financial and clinical requirements vary depending on pathway. Eligibility standards by pathway are set at:

(1) MACC group for children: Family income limit - 261% FPL; no resource limit.

(2) Katie Beckett: Child income limit - Special income limit for LTSS - federal benefit rate; resource limit - $4,000; no income or resource deeming.

b. Special Conditions. The special conditions apply only to the KB eligibility pathway. To be eligible, the child must have a disabling impairment and needs requiring the level of care typically provided in a health institution (NF, ICF-ID, LTH) and live at home. A cost-effectiveness test applies; that is, the cost of care at home must be at or below cost of care provided in a health care institution. The child must be otherwise ineligible for Medicaid based on family income,

c. Determination Process. The eligibility system considers all children seeking Medicaid eligibility in the MACC group for children first, in accordance with the income limits set in Part 30-00-1 of this Title and the MAGI eligibility process in Part 30-00-5 of this Title.

d. Retroactive Coverage. Retroactive coverage is available for KB eligible beneficiaries, but is unavailable for MACC group eligible beneficiaries, including children with special needs.

1.10 Expedited Eligibility

A. Expedited eligibility is a special process authorized under the State's Section 1115 demonstration for adults age nineteen (19) and over seeking LTSS in a home and community-based setting. The purpose of this special process is to provide a limited package of HCBS for no more than ninety (90) days to applicants who meet the need for LTSS in a home or community-based setting as specified in § 1.7(A)(2)(b) of this Part and prefer to remain in or transition to a home or community-based setting for a health institution while a full determination of eligibility is being made.

1. Eligibility criteria -- To be considered for expedited eligibility, new applicants must submit a full and completed application for Medicaid LTSS and self-attest to meeting the Medicaid LTSS general and financial eligibility requirements for their appropriate coverage group -- that is, elder, adult with disability, MACC group adult and so forth. Existing beneficiaries must notify an LTSS eligibility specialist and provide any supplemental information required to initiate an expedited eligibility review. The need for LTSS must be established in accordance with applicable functional/clinical criteria established by EOHHS by a licensed treating physician or appropriately qualified health practitioner or provider.

2. Applicable circumstances -- Expedited eligibility is the default eligibility for new applicants and existing non-LTSS Medicaid beneficiaries who meet the requirements set forth in this Part in the following circumstances:

a. Discharge from a hospital. Discharge must be to a home or community-based setting from a hospital or ancillary health institution after an acute care admission.

b. Discharge from a from a short-term health institution stay Discharge or transition to a home and community-based setting from a nursing facility or subacute care facility for a short-term stay or skilled rehabilitation if the services provided are not covered as a Medicaid LTSS benefit and, as such, Medicaid reimbursement for the stay is not required.

c. Expanded need. A person seeking LTSS eligibility who is receiving preventive level services authorized by EOHHS in accordance with Part 40-05-1 of this Title and has expanded needs or is determined by a treating health practitioner to have the need for in-home assistance to supplement skilled homecare or hospice services currently in place; or to extend to the period after skilled services have ended.

B. Expedited eligibility benefits are limited to maximum of: twenty (20) hours weekly of personal care/homemaker services; three (3) days weekly of adult day services; and/or limited skilled nursing services based upon level of need. Upon approval of Medicaid LTSS, the beneficiary qualifies to receive full coverage. The following also apply:

1. Limited duration -- The expedited eligibility benefit package is available for up to ninety (90) days or until the eligibility decision is rendered, whichever comes first.

2. Exemptions -- There is no PETI conducted in conjunction with expedited eligibility and, as a consequence, no required contribution toward the cost of care during the ninety (90) coverage period. Retroactive eligibility is not available, though costs incurred and unpaid for Medicaid covered services prior to the LTSS application filing date are considered when determining eligibility for full coverage.

3. Restrictions -- Under the terms of the State's Section 1115 demonstration waiver, expedited eligibility is not available for LTSS in a health institution setting.

1.11 Roles and Responsibilities

A. Persons seeking LTSS Medicaid eligibility must meet the general requirements that apply program-wide related to residency, citizenship, and cooperation, among others.

1. Agency responsibilities - The EOHHS is responsible for determining Medicaid LTSS eligibility, authorizing services, the appropriate level of care planning and service coordination, as dictated by setting, and enrollment in service delivery option of choice. Under the terms of interagency agreements, the DHS and

BHDDH have been authorized to determine all or some aspects of LTSS eligibility as an agent of the EOHHS.

2. Applicant Responsibilities -- Beneficiaries determined eligible through this pathway must provide accurate and timely information and the consent necessary for EOHHS, or its agent(s), to obtain the health care information required for the clinical eligibility determination.

1.12 Severability

If any provision in any section of this rule or the application thereof to any person or circumstances is held invalid, its invalidity does not affect other provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 00 - Long-Term Services

Medicaid Long-Term Services and Supports: Medically Needy Eligibility Pathway (210-RICR-50-00-2)

2.1 Scope and Purpose

A. Medically Needy (MN) eligibility for Medicaid long-term services and supports (LTSS), previously referred to as the "Flexible Test of Income", enables people with income above the federal benefit cap to obtain Medicaid LTSS coverage in certain circumstances. The federal benefit cap rate is 300 percent of the Supplemental Security Income (SSI) benefit rate and is the income eligibility ceiling for both the "special income" and home and community-based services (HCBS) LTSS pathways identified in Part 1 of this Subchapter.

B. Under the federal law, the LTSS MN pathway is for LTSS beneficiaries only without regard to type of care --institutional or HCBS settings. The provisions related to MN Non-LTSS Community Medicaid are set forth in Part 40-05-2 of this Title. LTSS MN is distinguished from MN Community Medicaid in that the spenddown is based on monthly projected expenses rather than the costs that must be incurred over a six (6) month budget period.

2.2 Legal Authority

A. Federal Authorities:

1. Federal Law: Title XIX, of the federal Social Security Act at: 42 U.S.C. § 1396a, 42 U.S.C. § 1396b, 42 U.S.C. § 1396k;

2. Federal regulations: These regulations hereby adopt and incorporate 42 C.F.R. §§ 435.301 *et seq*. (2016) 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.

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

B. State Authorities: Among other statutes, R.I. Gen. Laws Chapters 40-6 and 40-8.

2.3 Definitions

A. As used in this Part, the following terms are defined as follows:

1. "Beneficiary liability" means the LTSS beneficiary's financial obligation toward the Medicaid LTSS cost of care, as determined monthly.

2. "Budget period" means the period of time in which an applicant's income is measured for the purpose of determining eligibility.

3. "Federal cap" means 300 percent of the federal Supplemental Security Income (SSI) Program monthly payment rate.

4. "LTSS beneficiary" means a person who meets all the general, clinical/functional, and financial eligibility requirements for LTSS, or a person receiving Medicaid LTSS of any type regardless of living arrangement. The LTSS beneficiary has been previously referred to as an "institutionalized" individual.

2.4 Medically Needy Eligibility Determination Process

A. To be considered for the medically needy pathway, an otherwise Medicaid eligible person must have income above the federal cap of 300 percent of the SSI rate. The LTSS eligibility requirements for Medicaid LTSS are outlined in § 1.9 of this Subchapter and are set forth in greater detail throughout this Part. All LTSS applicants with countable income above the federal cap are automatically evaluated for the MN eligibility pathway. Total countable income must be at or below the projected cost for the type of LTSS the person is seeking or receiving, at the private pay rate, adjusted annually as set forth in § 2.4 of this Part.

B. Eligibility is determined in accordance with the following:

1. Excess income amount -- The person's countable income for the month is determined based on the provisions set forth in Part 40-00-3 of this Title, pertaining to the SSI methodology. If income is above the federal cap after all required disregards and exclusions have been applied, the medically needy income limit (MNIL) is deducted from remaining income. This is the total amount of excess income that must be absorbed to obtain MN eligibility for LTSS.

2. Income and Institutional Cost Comparison -- The projected cost of LTSS at the private pay rate in the applicable health institution -- (nursing facility (NF), intermediate care facility for intellectually/developmentally disabled individuals (ICF/I-DD), or long-term hospital (LTH) -- is deducted from the excess income.

a. If excess income is absorbed by the cost of LTSS, the person is MN eligible and the provisions related to the post-eligibility treatment of income (PETI), set forth in Part 8 of this Subchapter, are applied to determine the amount of person's gross income that is available to be applied toward the cost of care each month.

b. If excess income is not absorbed, the remaining income provides the basis for determining the LTSS MN spenddown for the projected budget

period once the PETI rules are applied. Allowable expenses are deducted in accordance with § 2.5.1(B) of this Part below.

3. Spenddown -- A MN LTSS spenddown is based on the amount of excess income remaining after all required reductions are taken in the PETI process. Income protected in the PETI process is unavailable and therefore is excluded in the calculation of the spenddown. Once protected income is subtracted, the total spenddown is the amount of allowable expenses a person must incur to meet the MNIL.

a. Otherwise Medicaid eligible due to a penalty. PETI does not apply when a person who is subject to penalty period for LTSS coverage is otherwise eligible for Medicaid. Therefore, during such a penalty period, in which Medicaid LTSS coverage is not available, all countable income is available for spenddown purposes.

b. Verification. The State determines whether the applicant/beneficiary has sufficient allowable expenses each month -- both incurred and projected -- to meet this spenddown. Proof that incurred allowable expenses meet the monthly spenddown may be required as indicated in § 2.5.1 of this Part below.

4. Monthly projected spenddown period -- The State uses a one-month budget period to determine beneficiary liability and therefore the amount of the spenddown required to maintain eligibility.

a. Start date. A one-month budget period begins with the first calendar month during which the person receives LTSS for any part of the month, applies for Medicaid coverage for that month, and meets all other requirements for Medicaid eligibility.

b. End date. A one-month budget period ends with the last calendar month during which the person received LTSS for any part of the month and meets all other eligibility requirements.

C. LTSS MN coverage begins on the first day of the budget period in which allowable expenses meet or exceed the spenddown requirement when using health insurance cost and noncovered health expenses to meet the MNIL. Eligibility becomes effective later than the first day of the month when a spenddown requirement is met using covered medical expenses. Medicaid LTSS coverage continues to the end of the budget period unless there is a change in income.

1. Penalty period and MN eligibility -- The penalty start date for a person seeking LTSS MN eligibility is the date the spenddown is met. If the spenddown is not met in the month of application or the next month, the person is ineligible for LTSS MN coverage and the State must determine whether Community Medicaid MN eligibility is available based on a six-month spenddown period.

2. Overlapping providers -- Applicants and beneficiaries are responsible for health expenses incurred before the date of eligibility. If receiving LTSS for more than one provider on the date that coverage begins, the applicant/beneficiary must decide which services he or she will be responsible for paying and which providers Medicaid will cover.

2.5 LTSS Medically Needy Allowable Expenses

A. The health expenses of the LTSS beneficiary and spouse and dependents, if applicable, may be used to obtain or retain MN eligibility if they qualify as allowable under this Part. The expenses may be paid or incurred and not paid depending on the deduction sequence, the age of the health bills, and whether the expenses are predictable and/or used for other eligibility purposes such as reducing resources or beneficiary liability for the cost of care.

B. For an incurred health expense to qualify as allowable for a LTSS MN spenddown, the following apply:

1. No third-party liability -- An allowable expense must not be eligible for payment by a third party. For these purposes, a third party could be individuals, entities or policies that are, or may be, liable to pay the expense including, but not limited to: other health care coverage, such as coverage through Medicare, private or group health insurance, long-term care insurance or through the Veterans Administration (VA) health system; automobile insurance; court judgments or settlements; or Workers' Compensation. Expenses incurred by the spouse or a financially responsible relative are NOT treated as a third-party liability if such expenses are allowable and the services are provided to the applicant or beneficiary.

2. Medically necessary -- The expense must be medically necessary. A necessary medical expense is an expense rendered for any of these situations:

a. In response to a life-threatening condition or pain;

b. Treat an injury, illness or infection;

c. Achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition;

d. Provide care for a mother and child through the maternity period;

e. Prevent the onset of a serious disease or illness;

f. To treat a condition that could result in physical or behavioral health impairment; or

g. When such services are provided or ordered by a licensed health care professional or provider they are presumed to be medically necessary. In

instances when such services are provided by some other person or entity, documentation of medical necessity may be required.

3. Single use -- The total amount of a health expense may not be used more than once to meet an eligibility or spenddown requirement. However, if only a portion of a health expense is used to meet the spenddown requirement in a budget period, the portion of the allowable expense that remains is a current liability and may be applied toward a spenddown requirement in a future budget period.

4. Retroactive coverage -- Allowable expenses incurred in the three (3) months prior to the date of application may be used to grant Medicaid MN coverage if all other eligibility criteria were met during the retroactive period. If not used to seek eligibility for this period, expenses incurred that are not used for this purpose may be applied in accordance with § 2.5.1(B)(4) of this Part below.

5. Deduction timeframes -- Health costs may qualify as allowable expenses when incurred:

a. During the current budget period, whether paid or unpaid;

b. Before the current budget period and paid in the current period,

c. Before the current period, remain unpaid, and continuing has been established; or

d. Paid during the current budget period by a government entity or program that does not receive Medicaid funding.

6. Loans -- Health expenses incurred before or during the budget period and paid for by a bona fide loan may be deducted if the expense has not been previously used to meet a spenddown requirement and the applicant or beneficiary or a financially responsible person establishes continuing liability for the loan. To be an allowable expense, all or part of the principal amount of the loan must remain outstanding at some point during the budget period. For these purposes, a bona fide loan means an obligation, documented from its outset by a written contract and a specified repayment schedule. Only the amount of the principal outstanding during the budget period, including payments made on the principal during that period, may be deducted.

2.5.1 Types of Allowable Expenses and Sequence of Deductions

A. The types of health and remedial expenses that qualify as "allowable" for the purposes of a MN spenddown are the same for both community Medicaid and LTSS. Such expenses include, but are not limited to: physician /health care provider visits; health insurance premiums, co-pays, co-insurance, and deductibles; dental and vision care; chiropractic and podiatric visits; prescription medications; tests and X-rays; skilled nursing and subacute care if not otherwise covered; home nursing care, such as personal

care attendants, private duty nursing and home health aides; audiologists and hearing aids; dentures; durable medical equipment such as wheelchairs and protective shields; therapy, such as speech, physical, or occupational therapy; transportation for medical care, such as car, taxi, bus or ambulance; and LTSS expenses at home or in a health institution at the State Medicaid reimbursement rate.

B. An expense is allowable for the Medicaid LTSS spenddown if it is for health insurance costs or specific types of Medicaid non-covered and covered services. The scope, amount and duration of the service determines whether it qualifies as an allowable expense as a Medicaid covered or non-covered service and, therefore, the order in which it is deducted from excess income. The sequence of deductions for allowable expenses is as follows:

1. Health insurance expenses -- The costs for maintaining insurance coverage for health care services and supports for both the person seeking coverage and any dependents. This category includes, premiums, co-pays, co-insurance and deductibles including for Medicare and commercial plans. Premiums for optional supplemental plans are not allowable expenses.

2. Non-Medicaid expenses -- These are expenses incurred for health care and remedial services that are recognized under State law but are not covered under the Medicaid State Plan or the State's Section 1115 demonstration waiver, such as home stabilization services and non-medical transportation.

3. Excess Medicaid expenses -- Includes expenses incurred for Medicaid covered services that exceed limitations on amount, duration, or scope established in the State Plan or Section 1115 demonstration waiver. Expenses allowed in this category must be medically necessary and may include both the costs incurred for an expanded service (such as dentures, in-patient behavioral health care for an extended period, contact lenses or a second pair of prescription reading glasses) and associated ancillary health costs (x-rays, needs assessments, lab tests, office visits and the like).

4. Covered Medicaid expenses -- These are incurred expenses that do not exceed limitations on amount, duration, or scope allowed under current federal authorities. They are deducted in chronological order based on the date of service beginning with the oldest expense.

a. An expense incurred in a month for which MN eligibility is approved is presumed to be a Medicaid covered expense unless documentation is provided to the State that it is not a covered service.

b. When an applicant for LTSS is receiving a service, or set of services Medicaid pays for in a daily or bundled rate, the items and services included in that rate are not separate allowable expenses whether provided in an institution, such as a NF or hospital, or home and community-based setting, such as a DD group home, assisted living residence, etc.

4. Health institution expenses -- Under the existing Medicaid State Plan, Rhode Island took the option under 42 C.F.R. § 435.831(3)(g)(1) to allow LTSS expenses incurred for both HCBS and health institutional care to be deducted from excess income. In accordance with the applicable federal requirements therein, the maximum amount allowed is the State monthly Medicaid reimbursement rate projected to the end of the budget period when paid or incurred. These regulations hereby adopt and incorporate 42 C.F.R. § 435.831(3)(g)(1) (2016) 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.

2.6 Health Institution and Income Cost Comparison

A. The following table sets forth the projected monthly private pay rates associated with each institutional level of care that are used to determine whether a LTSS applicant or beneficiary with excess countable income qualifies for LTSS MN eligibility with or without a spenddown. Figures are based on average costs reported in the Genworth Financial, Inc. 2017 survey of nursing facility providers (https://www.genworth.com/aging-and-you/finances/cost-of-care.html) and the McKinsey survey of LTSS non-governmental payers and providers (https://healthcare.mckinsey.com/) in Rhode Island, including for-profit and not-for-profit entities, for a semi-private room as of May 1, 2018:

RI: Projected Monthly Private Pay Costs by Institutional Level of Care -- 2018	
Type of LTSS	Monthly/Daily Rate
Nursing facility (average skilled)	$9,581/$319
Intermediate Care Facility for I-DD	$37,858/$1,261
Long-term hospital	$45,599/$1,519

B. The following table shows the State reimbursement for LTSS only. Incurred and paid non-LTSS health care costs are excluded from the rates except in health institutions (NF, ICF/I-DD, and LTH) and may be added toward the required spenddown if allowable.

RI: State Medicaid LTS-only Monthly Reimbursement Rates by Service – 2018 (Medical Services not included)	
Service	Monthly Rate
Nursing facility (average skilled)	$6,700

Assisted Living Certification for Category D	$1,400
Assisted Living Certification for Category F (enhanced/specialize)	$2,400
Shared Living --	$2,400
HCBS in a Home	$1,700
Eleanor Slater -- Hospital	$34,195
Zambarano/Tavares	$21,932
Other hospital	$24,000
DD at Home	$2,561
DD Share living	$5,001
DD Group Home	$9,412
Adult Day Services – Non-DD	$1,590

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 00 - Long-Term Services

SSI-Related Coverage Groups (210-RICR-50-00-3)

3.1 Institutionalized SSI Beneficiaries

This coverage group consists of individuals in a medical or nursing facility who would be eligible for SSI if living in the community. This includes individuals with sufficient income to meet personal needs while in the facility, but not enough income to meet their needs outside the community according to SSI and State Supplement Standards.

3.2 Non-Institutionalized SSI Beneficiaries

This coverage group consists of individuals in a medical or nursing facility who would not be eligible for SSI if s/he were living in the community. While in the facility these individuals are Medicaid eligible under a special income level for institutionalized individuals (the Federal Cap). The resources of institutionalized persons in this coverage group must be within SSI limits.

3.3 Residents of Long-Term Care Facilities

A. This coverage group consists of individuals who were eligible for Medicaid as residents or inpatients of Title XIX facilities or were, on the basis of need for institutional care, considered to be eligible for Medicaid in the month of December 1973. The Title XIX facilities are the Eleanor Slater Hospital and Zambarano Hospital.

B. Eligibility for Medicaid continues for these individuals as long as they:

1. Remain residents of the Title XIX facilities; and

2. Meet the eligibility conditions of Medicaid as of December 1973; and

3. Are in need of institutionalized care.

3.4 Short Inpatient Stays

A. This coverage group consists of SSI recipients who enter medical facilities, including acute care hospitals and Nursing facilities, and who intend to return to their community residences within ninety (90) days. The Omnibus Budget Reconciliation Act (OBRA) of 1987 provides for the continuation of full SSI benefits for up to three months. The intent of the OBRA provision is to allow individuals to retain their community residences while temporarily confined to a hospital or Long Term Care facility.

B. The eligibility requirements for continued SSI benefits are:

1. A physician must certify in writing that the individual's medical confinement is not expected to exceed ninety (90) days; and

2. The individual must certify in writing that s/he needs the benefit to maintain the home; and

3. Documents attesting to the above conditions must be received by the SSA not later than ten (10) days after the end of the month in which the individual entered the hospital.

3.5 Working Disabled

A. This coverage group consists of disabled persons who are working and who receive special SSI payments under Section 1619b of the Social Security Act. Individuals who received SSI payments in the month prior to institutionalization receive two (2) months of continued benefits when admitted to:

1. Eleanor Slater Hospital;

2. Zambarano Hospital.

3.6 Cash Assistance Beneficiaries

A. This coverage group consists of individuals who, whether or not they actually received cash assistance in December 1973 satisfy the following criteria:

1. Eligibility for cash assistance in December 1973 because they were blind or disabled under the State's approved Medicaid plan; and

2. For each consecutive month after December 1973, continued eligibility based on the December 1973 conditions of blindness or disability, and the other conditions of the plan in effect in December 1973; and

3. Income and resources within current SSI standards.

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 00 - Long-Term Services

Medicaid Long-Term Services and Supports Application and Renewal Process (210-RICR-50-00-4)

4.1 Overview

The purpose of this regulation is to set forth the Long-Term Services and Supports (LTSS) application review and renewal process in accordance with current State and federal laws and regulations.

4.2 Legal Authority

A. Title XIX of the U.S. Social Security Act provides the legal authority for the RI Medicaid program. Additionally, legal authority related to long-term services and supports is derived from the following sources:

1. State Law: R.I. Gen. Laws § 40-8-6.1

2. Federal Law: 42 U.S.C. § 1396a; 42 U.S.C. § 1396k; Section 1413(b)(1)(A) of the Affordable Care Act

3. Federal Regulations: 42 C.F.R. §§ 435.905 THROUGH 910; 42 C.F.R. § 435.912(c) (timelines).

4.3 Definitions

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

1. "ACA adults" means persons between the ages of 19 and 64 who are eligible for Medicaid authorized by the federal Affordable Care Act (ACA) of 2010.

2. "Additional documentation request" or "ADR" means the notice sent to applicants subsequent to an initial review of the application's completeness that identifies any additional information/forms that must be submitted, and any related deadlines, for a determination of eligibility to proceed.

3. "Application completeness" means the point in time when all information requested by the State, including the application and any ancillary required forms and authorizations necessary to determine eligibility, are date-stamped as received by the State.

4. “Application timeliness” means the specific time frame for making determinations of Medicaid eligibility as set forth in federal and State law, regulations and rules. The timelines vary in length depending on whether a functional/clinical eligibility determination is required.

5. “Clinical or functional eligibility” means the application of needs-based criteria to determine whether a person requires the level of care typically provided in an LTSS health institution as defined herein.

6. "Department of Human Services" or "DHS" means the State agency established under the provisions of R.I. Gen. Laws Chapter 40-1 that has been delegated the responsibility through an interagency service agreement with the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, to determine Medicaid eligibility in accordance with applicable State and federal laws, rules and regulations.

7. "DHS-2 application form" means the principal paper application form for Medicaid LTSS.

8. "Eligibility pathway" means one of the various ways authorized under the State’s Medicaid State Plan and/or Section 1115 demonstration waiver that a person may be found eligible for LTSS.

9. "Executive Office of Health and Human Services" or "EOHHS" means the State agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 which is designated as the “single State agency,” authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

10. "Financial eligibility" means the process for determining whether an applicant meets the income and resources requirements for Medicaid eligibility.

11. "Home and community-based services" or "HCBS" means the services and supports provided to Medicaid LTSS beneficiaries at home or in a community-based setting who would require the level of care associated with one of the three institutions (health care facilities identified below) recognized in federal Medicaid law if they were not receiving these services and supports.

12. "Institution" means one of the long-term care institutions recognized in federal Medicaid law and is a State-licensed health care facility where health and/or social services are delivered on an inpatient basis. For the purposes of this document, the term means long-term care hospitals and treatment facilities (LTHR), intermediate care facilities for persons with intellectual disabilities (ICF/ID), and nursing facilities (NF).

13. "Integrated eligibility system" or "IES" means the State's health and human services computer eligibility system - known as RI Bridges - which processes applications for Medicaid as well as for the programs and services administered by the DHS.

14. "Long-term services and supports" or "LTSS" means a spectrum of services covered by the Medicaid program for people with functional impairments and/or chronic illness that provide assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping).

15. "LTSS specialist" means a State agency representative responsible for determining eligibility for long-term services and supports, authorizing services, and/or providing assistance to people in navigating the Medicaid health care system.

16. "Needs-based criteria" means the basis for determinations of functional/ clinical eligibility for Medicaid LTSS including medical, social, functional and behavioral factors, and the availability of family support and financial resources.

17. "Supplemental forms" means the additional forms all LTSS applicants are required to complete.

18. "Types of LTSS" means the two forms of LTSS authorized under federal law and the State's Medicaid State Plan and Section 1115 waiver: Medicaid LTSS in health care institutions (NFs, ICF/IDs, and LTHR) and Medicaid home and community-based LTSS.

4.4 Summary of LTSS Eligibility Determination Process

A. Eligibility Factors. Evaluations of all applications for Medicaid LTSS are based on eligibility requirements or factors that fall into the following three categories:

1. General Eligibility Factors - Residency, citizenship and immigration status, third-party health coverage, age, health coverage, marital status, dependents (§ 40-05-1.9 of this Title).

2. Financial Eligibility Factors - Varies by eligibility pathway and the method for determining income eligibility in accordance with Part 40-00-3 of this Title.

3. Clinical/functional Eligibility - An applicant's health care and functional health care needs are evaluated based on information obtained from providers using pre-set needs-based criteria. The needs-based criteria for the NF, ICF-ID, and LTHR vary in accordance with the needs of the population served. Separate criteria related to disability status and LOC are also used for children seeking Katie Beckett eligibility. (Subchapter 10 Part 3 of this Chapter).

B. Planning and the Cost of Care. LTSS applicants/beneficiaries are also in engaged in several on-going and post-eligibility processes that ensure they participate in decisions about their care, and that necessary and appropriate services are authorized. Calculation of their liability to pay a share of the cost of LTSS care includes the spouse's and/or dependents' needs and other allowable expenses.

1. Person-centered Planning (PCP) - The person-centered planning process begins when an applicant decides to apply for Medicaid LTSS and continues throughout the eligibility determination process. The applicant/beneficiary and their health care preferences and goals drive the development of the plan (42 C.F.R. § 441, Subpart M).

2. Service Plan and Authorization - The service plan identifies the scope, amount and duration of services necessary to meet the new beneficiary's needs as articulated in the PCP process and other assessments; authorization allows payments to be made for these services.

3. Post-eligibility Treatment of Income (PETI) -- This is the process in which the State determines how much money a beneficiary must pay each month toward the cost of care. Income is calculated and deductions are then taken (also known as "allowances") to cover personal needs and non-Medicaid covered or incurred and unpaid health care expenses. The spousal impoverishment requirements in federal law are also applied, if appropriate, to exclude any of the beneficiary's income that must be set aside to provide financial support for a spouse and/or dependents in the community. (Part 8 of this Subchapter; 42 C.F.R. §§ 435.217; 435.726; 435.236).

4.5 Starting the Application Process

A. Applying for LTSS. All persons seeking initial Medicaid LTSS must apply, including existing Medicaid beneficiaries who are already covered through a non-LTSS pathway for parents/caretakers and adults eligible under the federal Affordable Care Act (ACA) expansion. Persons eligible for Community Medicaid (non-LTSS) are evaluated on a set of general, financial and functional/ clinical eligibility requirements in accordance with § 40-05-1.5.2 of this Title and Rhode Island's Medicaid Section 1115 waiver. The information existing beneficiaries must provide when applying for LTSS is limited to only those eligibility factors related to clinical / functional and financial eligibility not already known to the agency.

B. Application Points. The State is committed to pursuing a "No Wrong Door" policy that offers consumers multiple application and renewal access points which all lead to the State's IES. (§ 40-00-2.2 of this Title).

1. On-line, Self-Service - Persons seeking initial or continuing eligibility have the option of accessing the eligibility system on-line using a consumer self-service portal through links on the EOHHS (www.eohhs.ri.gov) and DHS (www.dhs.ri.gov) websites or directly through HSRI (HealthSourceRI.com).

Supplemental forms and required documentation may be uploaded directly on-line or faxed, emailed or U.S. mailed. The information applicants provide on-line is entered directly into the IES and processed electronically in real-time. The initial steps for applying on-line are as follows:

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

(1) Identity proofing. The applicant must provide personally identifiable information when creating an on-line account as a form of identify proofing. Verification of this information is automated.

b. Account matches. Once identity is verified, account matches are conducted to determine whether the applicant or members of the applicant's household have other accounts or are currently receiving benefits. The IES draws on information in an applicant's account when determining eligibility for other programs. This reduces the need for additional verification and supportive documentation in some circumstances.

2. Paper DHS-2 Applications - Paper forms may be completed on-site with assistance from LTSS eligibility specialists and/or submitted at various agencies, as indicated in § 4.5(D) of this Part below. Applications may also be mailed or faxed to the address identified on the DHS-2. Irrespective of point of receipt, all applications and supplemental forms are indexed scanned into the IES through the EOHHS central mail management system and assigned for review according to the type of assistance requested.

C. Application Packet. The application packet contains the several forms requesting the information necessary to determine whether a person is eligible for Medicaid LTSS. There are two types of forms required for Medicaid LTSS eligibility, however applying:

1. General Application Form - The DHS' "Application of Assistance", known as the "DHS-2", is the principal application form a person must complete when applying for Medicaid LTSS. The paper version of the DHS-2 is available on-line at: at one of the DHS offices listed here. Community agencies and LTSS providers may also be able to provide copies of the DHS-2. The DHS-2 is used for LTSS and as the basis for determining eligibility for: Supplemental Nutrition Assistance Program (SNAP), Child Care Assistance Program (CCAP), Community Medicaid for elders and adults with disabilities (EAD) who are seeking long-term care, the Sherlock Plan for persons with disabilities who work (SP), the State-funded optional supplemental security program (SSP) and the RI Works Program.

2. Supplemental Forms - All applicants for LTSS must also complete additional forms that provide the information necessary to review the application and/or determine various eligibility factors.

LTSS Required Supplemental Forms			
Name of Form	**Used in:**	**Details**	**Applicant sends to:**
DHS-2 Cover Sheet	Application	Identifies LTSS applicants and type of services requesting	Agency with DHS-2
CP-12 Applicant Choice	General Eligibility	Applicant must attest that information about types of LTSS (institutional and HCBS) has been provided	Agency with DHS-2
Clinical/functional evaluation by Health Care Provider, GW OMR PM 1 and supporting documentation	Clinical/functional eligibility	Form for health care provider to complete	Principal Health Care Provider (physician, NF, assisted living residence). Agency sends upon request and follows-up if no response by time of application review.
Consent Form, DHS-25M-CL Provider	Clinical/functional eligibility	Supplemental form for health provider which authorizes release of health care information. Two copies included in the application packet to be sent to health care provider and/or community agency Provider	Health Care Provider
Authorization to Obtain or Release Confidential Information, DHS-25 (New consolidated	General/financial eligibility	Release for non-medical confidential information	Agency with DHS-2

LTSS Required Supplemental Forms			
Name of Form	**Used in:**	**Details**	**Applicant sends to:**
form that incorporates DHS-91)			

3. Limits on Application Information - As the DHS-2 is an integrated application that is used across health and human services programs, applicants must answer questions that are sorted by program. Applicants are responsible for answering only those questions pertaining to eligibility for the programs for which they are applying:

a. On the paper application, the relevant questions are marked with the acronym associated with the specific programs for which the applicant is applying. “KB” means Katie Beckett, “LTSS” means long-term services and supports

b. Applicants using the electronic version of the DHS-2 may identify the programs for which they are applying upfront. The IES then automatically sorts the questions they must answer by their program(s) of choice.

D. Application Assistance. DHS and EOHHS eligibility specialists provide application assistance in completing all necessary forms, obtaining and submitting required documentation, and responding to inquiries or requests for information. Assistance is also available through:

1. The Division of Developmental Disabilities in the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) for adults with developmental/intellectual disabilities seeking Medicaid. The division also provides specialized assistance and case management services to beneficiaries.

2. The Division of Elderly Affairs (DEA) of the DHS is an additional source of application services for persons seeking LTSS in the home and community-based setting. These services are provided through community agencies under contract with DEA which also provide needs assessments to applicants and case management services to beneficiaries.

3. Community-based certified assisters including State Health Insurance Assistance Program (SHIP) counselors working through local Senior Centers and THE POINT, the State’s Aging and Disabled Resource Center (ADRC).

E. Applicant Rights. The State is responsible for upholding the following rights of Medicaid LTSS applicants:

1. Authorized Representatives - Applicants may designate someone to serve as an authorized representative to help or act on their behalf in dealing with agency eligibility and LTSS specialists.

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

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

4. Appeals - The agency accepts appeals and holds hearings on actions related to eligibility decisions in accordance with Part 10-05-2 of this Title.

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

6. Non-LTSS Medicaid Beneficiaries - Existing Medicaid beneficiaries who are seeking to expand their coverage to include LTSS may initiate the application process by requesting a change in coverage through their on-line account or by contacting DHS eligibility specialists.

4.6 Submitting the Application

A. Completion of Forms and Signature. All application forms must be complete and signed before being submitted. To ensure equity between people who apply on-line versus through the DHS-2, an application that is not completed and signed will not be accepted and will be returned. The IES accepts electronic signatures.

B. Valid Information. Information provided on the application must be validated in accordance with one or more of the following methods to determine eligibility:

1. Attestation - Applicants must attest to the truthfulness and accuracy of the information they provide by signing, under penalty of perjury, the paper application and supplemental forms in ink, or if applying on-line, through an electronic signature. An applicant's responses on the signed application (so-called "attestations") are accepted as valid without further verification or proof for a limited range of eligibility factors, such as State residency and marital status or relationship.

2. Electronic Data Matches - Applicant attestations related to income, immigration status, Medicare coverage, private health insurance, and several other eligibility factors are verified automatically through the IES using electronic matches with various federal and State data sources. Applicants are asked to provide their consent for these electronic data matches on the paper and on-line forms. If these matches fail to validate applicant attestations, the applicant will

receive a written request for additional clarifying or supporting documentation before action is taken on eligibility through an ADR.

3. Supporting Paper Documentation/Proof - In instances in which eligibility factors cannot be electronically verified due to a lack of data sources or an information discrepancy, an applicant must submit additional documentation to prove the truthfulness and accuracy of attestations or the full scope of information necessary to evaluate an eligibility factor. The application forms for LTSS identify eligibility factors that require paper documentation.

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

4.7 Application Cycle

A. Application Receipt and Filing date. The date a signed and completed application form is manually or electronically date-stamped as received by the agency is the application filing date. The application filing date is used to determine the eligibility date for LTSS coverage. The eligibility date is the first day of the month in which an application is filed. Retroactive coverage is available if a person would have qualified for LTSS Medicaid for up to three (3) months prior to the eligibility date. A signed, completed application form is submitted by any of the following means:

1. Electronically through the self-service portal;

2. A paper copy is date-stamped as received by State agency staff;

3. Electronically dated if uploaded, e-mailed, faxed, or scanned;

4. Delivered in-person and date-stamped by State agency staff.

B. Application Data Entry and Tracking. Once an application has been filed, the State agency is responsible for ensuring all required information is scanned or entered into the IES and updated and tracked until eligibility is determined.

C. Application Review Timeline. Under federal regulations, LTSS eligibility determinations are considered untimely if they are not made within the ninety (90) day timeframe beginning on the filing date provided all required sections of the application form(s) have been completed and signed, as appropriate, and submitted by that date, along with any documentation necessary to determine an applicant's identity.

1. In accordance with 42 C.F.R. § 435.912, the State may not be able to determine eligibility within this timeframe in unusual circumstances, such as when the

agency cannot reach a decision because: the applicant or health care provider delays or fails to take a required action, or there is an administrative or other emergency beyond the agency's control.

2. An application is considered incomplete until all the information required to determine eligibility has been date-stamped as received by the State. Additionally, State-only interim payments may be available in instances in which the State has not made a determination of eligibility on a complete application, as defined in § 4.8 of this Part.

D. Application Open and Duty to Report Changes. An application must be open for the State to determine eligibility. An application remains open for 180 days from the date the application form is filed, including any reinstatement review period, as set forth in subpart § 4.9(B)(5) of this Part. Applications will be automatically withdrawn and closed at the end of the open period unless the State is responsible for delays in processing materials related to LTSS eligibility factors. Applicants must inform the agency of any changes in an eligibility factor, such as income, resources, health status, within ten (10) days of the date the change occurred during the 180-day period in which the application remains active. General information related to address, authorized representative, immigration status and the like must be updated/corrected as well as the following:

1. Functional/clinical eligibility factors -- In accordance with standing EOHHS rule pertaining to LTSS needs-based determinations, Part 5 of this Subchapter information related to health and functional status must be no more than (ninety) 90 days old in order to make a fair and accurate assessment of functional/clinical eligibility. Therefore, the must be provided with any information from a health care provider that may in anyway be related to an applicant’s level of care needs within the ten-day reporting period.

2. Financial eligibility factors - Application information that is not verified by an electronic data source must be updated/corrected during the period in which an application is open within the required ten-days. This includes, but is not limited to, any information related to changes in income provided from outside the State, resources, home maintenance needs, and health care costs and expenses.

4.8 Application Completeness and Eligibility Determination Timelines

A. Complete Application. Under State law, an LTSS application is considered complete when the application form and “attachments and supplemental information as necessary” provide the agency with sufficient information to determine eligibility.

B. Scope of Information Required. The information required for an application to be considered complete is not fixed. An applicant’s unique circumstances dictate which factors must be considered when determining eligibility and, as such, when there is sufficient information to determine eligibility. By signing the application, the applicant self-attests to the truth of the information he or she provides on any required forms submitted to the agency. To the full extent feasible, this information is verified through

electronic data sources. However, when no electronic sources are available, the applicant must provide various types of documentation as proof to support self-attestations.

C. The full range of information that may be required for an application to be complete varies depending on the applicant's situation and the type of verification/proof required. A list of eligibility factors and types of acceptable documentation are located on the EOHHS website at: http://www.eohhs.ri.gov/ProvidersPartners/FormsApplications.aspx and is also available on paper by contacting the DHS-LTSS coverage line at (401) 415-8455.

4.9 Information Tracking and Pre-Eligibility Screening and Review

A. Application Information Tracking. Once the application filing date is established, all information submitted to the agency is entered or scanned into the applicant's account in the IES and tracked going forward. LTSS eligibility specialists may provide information, upon request, of the status of any application materials the agency receives after the filing date.

B. Review of application completeness. Within thirty-five days (35) after the application filing date, a review is conducted of any pending application. The purpose of this process is to identify any outstanding information and/or additional supporting documentation or proof that is necessary to determine eligibility. Based on this screening and review:

1. Additional Documentation Request (ADR) - The IES generates a written notice informing the applicant of any outstanding/additional information necessary to complete the application.

2. ADR Response -Applicants must respond to the ADR within fifteen (15) days (ten days (10) from date of the notice plus five (5) days to cover mailing time). Information may be emailed, faxed, mailed, uploaded into the applicant's account or delivered in-person. At any time before the ADR response is due, an applicant may make contact the DHS office, at number indicated on the form, and request for a good cause extension. Such extensions are granted for an additional fifteen (15) days when the applicant provides proof that the inability to respond was due to returned mail, a debilitating health care condition or emergency situation, or the negligence or failure of a third-party.

3. Application Complete - If all requested information is received and the application is considered complete, the process for determining eligibility proceeds. While conducting the eligibility determination, an LTSS eligibility specialist may find that further information is required from the applicant and/or a current or prospective provider to establish a plan of care and/or authorize services. A supplemental ADR may be sent out at this juncture with an appropriate response time

4. Application Denial - If the information requested in an ADR is not received when due, the process for denying the application for non-cooperation is initiated.

The applicant has the right to appeal the denial in accordance with the provisions of Part 10-05-2 of this Title.

5. Application reinstatement - An application denied on the basis of non-cooperation under this subpart may be reinstated if the information requested by the applicant is provided to the State within no more than thirty (30) days from the date the denial takes effect if there is time remaining in the ninety (90) day application review period. In such circumstances, a new application review period begins on the application reinstatement date and eligibility dates back to the original application filing date, providing all information subject to change has been updated. If the initial ninety (90) day application review period has expired, the reinstatement date is treated as a new application filing date and the start date of eligibility is determined accordingly.

4.10 Applicant and Agency Responsibilities

A. Applicant responsibilities include:

1. Full responses -- Responding to all questions related to LTSS eligibility on the application and any required supplemental forms;

2. Providing any documentation requested to verify the information on the form at the time the application is submitted and at any point in which change reporting is due;

3. Promptly sending to health care providers the signed clinical evaluation forms and associated releases and ensuring these forms are returned in a timely manner.

4. Clinical status --Reporting any changes in health status, such as trauma or marked decline in functional ability, financial circumstances, such as sale of a home, asset loss or windfall, and/or household composition, such as death or divorce of a spouse, that may affect the determination of level of need after the initial application is submitted during the time the application is pending action by the State.

5. Signature and truthfulness -- Signing the form to provide consent for the determination of eligibility and the verification of information through electronic sources and to attest to the truthfulness of application responses. In the event of a death, the form may be signed by an authorized representative or next of kin.

6. Duty to Report -- Applicants must report changes in any information included on the application and supplemental forms within ten (10) days from the date the change takes effect while the application is open. Self-reports are permitted through the eligibility system consumer self-service portal as well as in person, via fax, or mail. Failure to report in a timely manner may result in the denial of an application based on non-cooperation.

7. Documentation/proof -- Applicants must provide any documentation or proof that otherwise cannot be obtained related to any eligibility factors subject to change upon written request. The information must be provided within the time frame specified in the notice stating the basis for making the agency's request. Failure to respond in a timely manner and/or to provide the information requested without good cause is considered to be non-cooperation and is grounds for denial.

8. Financial resources -- Applicants must, as a condition of eligibility, take any necessary steps to obtain annuities, pensions, retirement and disability benefits along with any other forms of assistance available for support and maintenance that may be identified by the agency, in writing, in accordance with § 40-00-2.5 of this Title. Good cause exceptions are considered when requested in writing.

B. State Agency responsibilities include:

1. Assistance -- Applicants who are incapacitated or are otherwise unable to fulfill these responsibilities on their own or with the assistance of an authorized representative may request additional assistance from an LTSS eligibility specialist. The EOHHS reserves the discretion to authorize such assistance the Secretary or his or her designee deems appropriate.

2. Voluntary Withdrawal - An applicant may request that an application for Medicaid benefits be withdrawn at any time either through their secure on-line account or by submitting the request in writing via the U.S. Mail or fax to the EOHHS or DHS agency representative. The Medicaid agency sends a notice to the applicant verifying the time and date of the voluntary withdrawal and indicating that the applicant may re-apply at any time.

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

4. Application Timeliness -An applicant may appeal and request a hearing on the basis of the timeliness if the State fails to provide notification of outstanding documentation and make a determination of eligibility on an application within the ninety (90) day review period.

5. State Payments - In accordance with R.I. Gen. Laws § 40-8-6.1, an LTSS provider may request State-only payment for LTSS if a determination of eligibility on a completed application, as defined herein, has been pending for more than ninety (90) days without action taken by the State.

4.11 Renewal of Medicaid LTSS Eligibility

A. LTSS Medicaid financial and general eligibility must be re-evaluated at least once a year. This annual review is now referred to as a renewal. Federal regulations [42 C.F.R. 435.916(b)] require these annual reviews to consider only those eligibility factors that are subject to change and, to the full extent feasible, utilize electronic data sources for verification purposes. Accordingly, LTSS Medicaid renewals require beneficiaries to review information from the IES on key general and financial eligibility factors that has been updated by internal and external data sources, and report any inaccuracies or changes. The requirements for general and financial eligibility renewals for Medicaid LTSS are conducted in accordance with § 40-00-2.7 of this Title.

B. Clinical and functional eligibility re-evaluations are also required, but may be performed annually or less frequently depending on the expected scope and duration of the need for LTSS. The requirements for clinical and functional eligibility re-evaluations are conducted in accordance with Part 5 of this Subchapter.

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 00 - Long-Term Services

Medicaid Long-Term Services and Supports: Functional/Clinical Eligibility (210-RICR-50-00-5)

5.1 Overview

The process for determining function/clinical eligibility for long-term services and supports (LTSS) centers on a comprehensive evaluation that includes a functional assessment and consideration of each applicant's unique medical, social, physical and behavioral health needs. The results of this evaluation process are used to determine whether, and to what extent, an applicant has the need for the level of care typically provided in a nursing facility (NF), intermediate care facility for persons with intellectual or developmental disabilities (ICF-I/DD), or long-term care hospital (LTH). Under the terms of the Medicaid State Plan and the State's Title XIX, Section 1115 demonstration waiver, a person must have this level of need and meet both the non-financial and financial eligibility requirements set forth in this Part to qualify for Medicaid LTSS coverage in one of these institutions, at home, or in a community-based service (HCBS) setting.

5.2 Legal Authority

A. This Part is promulgated pursuant to the following federal and state authorities:

1. Federal Law -- Title XIX of the U.S. Social Security Act 42 U.S.C. § 1396a, Sections 1115, 1902, 1903, 1905, 1915, 1919.

2. Federal Regulations -- 42 C.F.R. Part 440 including §§ 440.40, 440.70, 440.150, 440.155, 440.180, 440.181, 440.182.

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

B. State Authority RI Gen. Laws §§ 40-8.9.9(c); 40-8.10-3; 40-8.13, 42-7.2-5(6)(v); 42-66.6, 40.1-22.

5.3 Definitions

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

“Activities of daily living" or "ADLs” means the routine activities that people tend do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring, and mobility and ambulation. The need

for assistance with medication management and personal hygiene is also considered an ADL.

2. “Community supported living services for I/DD” means one or more of the home and community-based Medicaid LTSS services and supports identified in §50-10-1 provided to assist an intellectually/ developmentally disabled person with the activities of daily living in a setting such as primary residence, the home of another, a BHDDH group home, or other community living setting arrangement where such services and supports are available.

3. "Department of Behavioral Healthcare, Hospitals, and Developmental Disabilities" or "BHDDH" means the entity within the executive branch of Rhode Island State government that serves as the mental health authority and administers LTSS programs funded in whole or in part by Medicaid for persons with intellectual or developmental disabilities and serious mental/behavioral health needs.

4. "Department of Children, Youth and Families" or "DCYF" means the State agency responsible for administering child protective and behavioral health services for children and youth, and their families, who are at-risk for or in the care and custody of the State, including several LTSS programs funded in part by Medicaid and CHIP.

5. "Department of Human Services" or "DHS" means the State agency that has been delegated responsibility for processing Medicaid LTSS eligibility through and providing functional assessments and case management services to certain applicants and beneficiaries in accordance with the terms and conditions of an interagency agreement with the EOHHS.

6. "Division of Elderly Affairs" or "DEA" means the unit within the DHS with responsibility for administering the State's HCBS co-pay program for persons who do not qualify for Medicaid LTSS as well as conducting assessments for certain Medicaid HCBS programs under RI General Laws and the terms and conditions of an interagency agreement with the EOHHS, the Medicaid Single State Agency in Rhode Island.

7. "Executive Office of Health and Human Services" or "EOHHS" means the entity within the executive branch of Rhode Island state government that is designated as the Medicaid Single State Agency in RI General Laws and the Medicaid State Plan and that, in this capacity, is responsible for overseeing the administration of all Medicaid-funded LTSS in collaboration with the health and human services agencies under the office's jurisdiction.

8. “Functional disability” means a deficit or deficits in the capacity to perform the activities of daily living and/or the instrumental activities of daily living of sufficient magnitude that alone, or in conjunction with certain health conditions,

constitutes a need for the level of care LTSS typically provided in an institutional setting.

9. “Instrumental activities of daily living" or "IADLs" means the skills a person needs to live safely and successfully in a residential setting of choice without outside supports. Such skills include, but are not limited to, using the telephone, traveling, shopping, preparing meals, doing housework, taking medications properly, and managing money.

10. “Level of care” means the amount of services and supports necessary to meet a person’s needs. When associated with a licensed health care institution, the term refers to the set of services and supports the institution is authorized and typically provides to people with a specific range of needs.

11. “Minimum Data Set” or “MDS” means a component of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.

12. “Needs-based criteria” means the health and functional status factors used in the determination of LTSS functional/clinical eligibility to assess a person’s need for the level of care provided in a nursing facility, ICF/ID, or certain hospital settings.

5.4 Assessments for Needs-Based Level of Care Determinations

A. The scope of services accessible to a beneficiary varies in accordance with a person’s needs, including his or her goals and preferences, the range of services and supports available under the State’s Medicaid State Plan and Section 1115 demonstration waiver, as well as federal and State regulations, rules or laws. The range of available authorized service options varies with each type of health institution (NF, ICF/I-DD, LTH), as the populations they serve have a range of service and support needs that also vary. As indicated in the following sections, the service options available to a person who meets the functional/clinical eligibility requirements for LTSS associated with one of these institutions is tied to the scope of his or her service needs at the time of application and in subsequent reassessments of need.

B. The functional/clinical eligibility determination process uses needs-based criteria drawn from a variety of sources. The process is initiated when the information necessary to evaluate an applicant's current health status and functional service needs become available to the State through one or more of the following sources:

1. Health care practitioner evaluation --The application includes a clinical evaluation form that must be completed by a treating, licensed health care practitioner with first-hand knowledge about the health status and functional needs of an applicant. The signed and completed form, and any required

associated documentation, provide the baseline for determining an applicant's needs level.

2. Health records and documentation -- Applicants must provide the State with the authorization to obtain health records and other forms of clinical documentation from health care providers and practitioners who have or are providing care to the applicant.

3. Health institution care/service plans -- Agency representatives from across the EOHHS agencies obtain information from health providers who assess and/or develop care/service plans for applicants who have or are receiving services or are about to be discharged.

4. HCBS functional assessment -- The State requires in-depth functional assessments of applicants seeking home and community-based services to ensure they can obtain the appropriate services safely and effectively in the setting of choice. The results of the assessments also assist in care planning and guide the authorization of services. As the State pursues a "no wrong door" approach, these assessments may be conducted by agency representative working for the State or various community entities using assessment tools that, although sometimes variable, focus on the same set of functional abilities and limitations.

a. NF level of care- HCBS. Responsibilities for HCBS functional assessments are shared across the EOHHS agencies.

b. ICF/I-DD level of care -HCBS -- Agency representatives in the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) conduct assessments of all applicants seeking the ICF/I-DD level of care without regard to setting.

c. LT Hospital level of care -HCBS. The EOHHS agency representative that determine the NF level of care assess applicants for the HCBS Habilitation Program that serves people with severe disabilities that occur in adulthood. BHDDH agency representatives conduct assessments of persons with serious and persistent behavioral health needs seeking Medicaid LTSS in a community-based congregate setting.

5.5 Development of Plan of Care, Service Planning and Authorization, and Case Management

A. The development of a plan of care is a multifaceted and multilayered process that may start prior to making a request for Medicaid LTSS if a prospective applicant and his or her family are seeking LTSS information and referral or counseling on the available LTSS options. In instances in which an applicant by-passes these options, care planning typically starts at the point of application and continues after a determination of level of care has been completed and services have been authorized. The core elements of the care planning process include, but are not limited to:

1. Person-centered -- Irrespective of the type of Medicaid LTSS a person is seeking (health institution v. HCBS), the care planning process is driven by an applicant's health care goals, expectations and choices.

2. Health institutions and service planning -- Federal regulations require that health institutions providing Medicaid funded LTSS conduct in-depth evaluations that consider a prospective resident's needs, values, and preferences when establishing a plan of care. Agency representatives consider the results of these evaluations when determining level of care, assisting in the development of the plan of care, and authorizing services. In addition:

a. NF and PASRR. In accordance with federal law, the State Preadmission Screening and Resident Review (PASRR) evaluation for all prospective NF residents focuses on cognitive, developmental and intellectual disabilities and behavioral health conditions that may require specialized services in a health institution. The results of this evaluation are used to incorporate specific services into the plan of care for applicants determined to have special needs as set forth in subsection § 5.7 of this Part below. The State must authorize payment for any such services included in the plan of care for Medicaid beneficiaries.

b. HCBS transitions. Health institutions must inform prospective residents and patients, as well anyone about to be discharged, who needs continuous LTSS about HCBS options. This information must be considered and recorded in any continuity of care service plans. NF and ICF/I-DD health institutions must also report to EOHHS any Medicaid applicant or beneficiary expressing a preference for HCBS options, as indicated subsection § 5.5 of this Part.

2. HCBS care planning -- HCBS person-centered planning supports an individual's right and ability to share his or her desires and goals, to consider different options for support, and to learn about the benefits and risks of each option. The essential elements of this process are set forth in in Subchapter 10 Part 1 of this Chapter.

B. For Medicaid LTSS coverage to begin, services must be authorized. Both the needs assessment and care planning process provide the critical information Agency representatives require to develop and authorize a service plan that meets the individual needs of a beneficiary. The scope of service planning from this point may be broadened or targeted more narrowly depending on whether a beneficiary is currently receiving or has chosen the type of LTSS and/or a service option.

1. Type of LTSS and service setting and delivery options - The Medicaid LTSS authorization of services is a function of the level of care determination and the applicant/beneficiary choice of the available LTSS type (health institution and/or HCBS) and service options therein. LTSS type and options are: health institution (NF, ICF/I-DD, LTH) or HCBS (assisted living residence, PACE, home care,

shared living, IDD group home, habilitation at home or in a congregate setting, personal choice self-directed care). Availability of service options is based on the extent of a person's need for a particular institutional level of care -- that is, whether that need meets the applicable criteria to qualify as high or highest or some level within these categories for persons with intellectual/developmental disabilities.

2. Service plan – An agency representative or community representative includes a service plan that incorporates the results of the care planning process into the plan authorizing LTSS type and service option. Accordingly, the service plan identifies the scope of authorized services in a health institution (such as skilled v. custodial in a NF) or in an HCBS setting (such as degree of supervision, number of homemaker v. skilled hours, and/or the availability of direct supports.)

C. Case management is a set of inter-related activities that ensure access to coordinated Medicaid LTSS and the monitoring of service needs and outcomes. Case management is an LTSS covered service under the Medicaid State Plan and Section 1115 waiver and may be provided by agency representatives, Medicaid managed care plans, community-based providers and organizations, and/or other contractual case management entities authorized by the State. Depending on the agency and the population served, this may be performed by multiple entities working in collaboration or a single entity. In addition:

1. Conflict-free -- Case management must be conflict free to the full extent feasible. Accordingly, persons or entities providing LTSS case management services should not have a fiduciary interest in or influence over the scope, amount, or duration of Medicaid LTSS that beneficiaries receive. In instances in which such conflicts appear or may exist, the State is bound by federal law to establish firewalls that ensure that care management activities are performed independently, in accordance with State standards, and under the direction of agency representatives. The State reserves the discretion to limit or terminate any arrangement for case management services that does not operate in compliance with these firewalls or that otherwise fails to serve the best interests of beneficiaries.

2. Scope of Services -- Case management services include, but are not limited to, assisting in or conducting screening and/or more in-depth assessments prior to and during the eligibility determination process, facilitating the person-centered planning process, aiding in the development of service plans, conducting periodic reviews and reassessments of functional/clinical needs, and coordinating services with the beneficiary's primary care and community service providers, LTSS program representatives, agency LTSS specialists, and family members when appropriate.

5.6 Nursing Facility (NF) Needs-based Level of Care Determinations

5.6.1 Overview

Under Rhode Island law, any health care institution licensed as a NF and certified for Medicare and Medicaid is authorized to provide skilled nursing and custodial care. Many facilities in the State also have the authority and capacity to offer subacute care, typically in the form of rehabilitation services, limited skilled nursing, and/or hospice care.

5.6.2 NF Service Classifications

A. The NF service classifications are designed to provide service options that reflect the scope and intensity of the beneficiary's need for the level of care typically provided in a nursing facility.

1. Highest need -- Beneficiaries in this classification have access to all the Medicaid LTSS covered services they need at home, in the community, or in a nursing facility, in accordance with their plan of care.

2. High need -- Beneficiaries in the high classification have needs that can be met safely and effectively at home or in a community-based Medicaid certified LTSS setting such as an assisted living or shared living residence. Accordingly, these beneficiaries have access to the full array of State Plan and Section 1115 demonstration waiver home and community based services required to meet their needs as specified in the person-centered individual plan of care.

B. To determine the level of care and appropriate service classification, agency representatives review the materials provided from the sources identified in § 5.4 of this Part and, as appropriate, the most current Minimum Data Set (MDS) Tool for NF care. To make the final determination of care needs, the results of this review are mapped against the needs-based and institutional level of care criteria.

5.6.3 Application of NF Needs-Based Criteria

A. The NF level of care determination focuses on health status and functional abilities as well as social and environmental factors and the availability of personal supports. The needs-based criteria reflect both best practices across the state and the prevailing standards of care within the LTSS community in Rhode Island.

1. Functional criteria –The functional disability criteria focus on the scope of a person’s need for assistance with Activities of Daily Living (ADLs) such as bathing, toileting, dressing, transferring, ambulation, eating, personal hygiene, medication management, and bed mobility. To determine the scope of need, agency representatives consider the extent to which the level of assistance a person requires falls into one of the following categories:

a. Total dependence (All Action by Caregiver): The person does not participate in any part of the activity.

b. Extensive Assistance (Talk, Touch, & Lift): The person performs part of the activity, but caregiver provides physical assistance to lift, move, or shift individual.

c. Limited Assistance (Talk and Touch): The person is highly involved in the activity but receives physical guided assistance that does not require lifting of any part of him or her.

2. Health Status Criteria –The needs-based health status criteria for a NF level of care deal with cognitive, behavioral and physical impairments and chronic conditions that require extensive personal care and/or skilled nursing assessment, monitoring and treatment on daily basis.

B. Persons with highest need for a NF level of care have the choice of obtaining services in a NF or HCBS setting.

1. Needs-based criteria – A person is determined to have highest need when the results of the functional/clinical assessment indicate he or she:

a. Requires extensive assistance or total dependence with at least one of four specific ADLs – toileting, bed mobility, eating, or transferring and limited assistance with at least one other ADL; or

b. Has one (1) or more unstable medical, behavioral, cognitive, psychiatric or chronic recurring conditions requiring nursing assistance, care and supervision daily; or

c. Lacks awareness of needs or has a moderate impairment with decision-making skills AND has one (1) of the following symptoms/conditions, which occurs frequently and is not easily altered: wandering, verbally aggressive behavior, resisting care, physically aggressive behavior, or behavioral symptoms requiring extensive supervision; or

d. Requires skilled nursing assessment, monitoring, and care daily for at least one of the following conditions or treatments: Stage 3 or 4 skin ulcers, ventilator, respirator, IV medications, naso-gastric tube feeding, end stage disease, parenteral feedings, 2nd or 3rd degree burns, suctioning, or gait evaluation and training; or

e. Requires skilled nursing assessment, monitoring, and care on a daily basis for one or more unstable medical, behavioral or psychiatric conditions or chronic or reoccurring conditions related, but not limited to, at least one of the following: dehydration, internal bleeding, aphasia, transfusions, vomiting, wound care, quadriplegia, aspirations, chemotherapy, oxygen, septicemia, pneumonia, cerebral palsy, dialysis, respiratory therapy, multiple sclerosis, open lesions, tracheotomy, radiation therapy, gastric tube feeding, behavioral or psychiatric conditions that prevent recovery.

2. Exceptions -- Otherwise Medicaid LTSS-eligible persons who do not meet the needs-based criteria may be deemed to have the highest need for a NF level of

care if an agency representative determines there is a critical need for Medicaid LTSS in a nursing facility due to special circumstances. These special circumstances must adversely affect the person's health and safety and be related to one of the following:

a. Loss of primary caregiver, due to hospitalization, debilitating illness, or death of a spouse, caretaker sibling, or adult child;

b. Loss of living situation, due to a fire, flood, foreclosure, or sale of principal residence as the result of the inability to afford to maintain housing;

c. A principal treating health care practitioner, or prior to ending an acute care hospital stay, a discharge planner indicates, based on a functional/clinical assessment, that the health and welfare of the applicant/beneficiary is at imminent risk if services are not provided or if services are discontinued;

d. The applicant/beneficiary met the highest NF level of care criteria on or before June 30, 2015 and chose to receive Medicaid LTSS at home or in a community-setting and the beneficiary reports he or she has experienced a failed placement that, if continued, may pose health or safety risks; or

e. The beneficiary was admitted to a hospital from a NF and is being discharged to the same or another NF upon discharge within any given forty (40) day period.

C. Persons with a high level of need for the NF level of care have a choice of HCBS service options but are restricted from receiving Medicaid LTSS in a NF.

1. Needs-based criteria -- Beneficiaries are deemed to have a high need for a NF level of care when one of the following is met:

a. Require at least limited assistance daily with at least two of the following ADLs: bathing/personal hygiene, dressing, eating, toilet use, walking or transferring; or

b. Require skilled teaching or rehabilitation daily to regain functional ability in at least one of the following: gait training, speech, range of motion, bowel or bladder control; or

c. Have impaired decision-making skills requiring constant or frequent direction to perform at least one of the following: bathing, dressing, eating, toilet use, transferring, or personal hygiene; or

d. Exhibit a need for a structured therapeutic environment, supportive interventions, and/or medical management to maintain health and safety.

2. Exceptions –

a. An LTSS applicant who is currently receiving non-LTSS Medicaid coverage may qualify for HCBS expedited eligibility as set forth in Part 50-00-1 of this Title pending completion of a full determination of level of care for a period of no more than ninety (90) days.

b. An applicant for Medicaid LTSS who is not a current beneficiary may qualify for HCBS expedited eligibility upon completion of a preliminary assessment by a treating health care practitioner indicating that absent immediate access to this limited package of services, the applicant must be admitted to a health care institution.

c. An LTSS applicant who is a current Medicaid beneficiary who has received expedited eligibility for a period of ninety (90) days may be deemed to meet the high level of care if:

(1) A full level of care of determination has not been completed by the end of the expedited eligibility period; and

(2) The applicant meets the financial eligibility requirements for an LTSS eligibility pathway identified in Subchapter 00 Part 1 of this Chapter; and

(3) The applicant's treating health care practitioner indicates that the discontinuation of HCBS will adversely affect the applicant's health and safety and/or require immediate admission into a NF or hospital.

5.6.4 LTSS Preventive Services

LTSS Preventive Need. Beneficiaries who meet the needs-based criteria for the LTSS preventive level of care are eligible for a limited range of home and community-based services and supports along with the full range of IHCC group benefits they are entitled to receive. The goal of preventive services is to optimize health to delay or avert institutionalization or more extensive and intensive home and community-based care. Rules pertaining to the LTSS preventive level of need are located in Part 40-05-1 of this Title.

5.6.5 Transitions to HCBS

Nursing facilities are required to refer to EOHHS any LTSS beneficiary who expresses a preference to obtain LTSS at home or in a community-based setting. Specifically, a Medicaid beneficiary is entitled to receive transition counseling if responding affirmatively to MDS Section Q, question 0500.This question asks whether the beneficiary wants to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community. Agency representatives also pro-actively identify beneficiaries who may be interest in HCBS options. The team reviews

functional and clinical data, including utilization, to identify possible candidates for a transition.

5.6.6 Reassessment of NF Level of Care Needs

A. All Medicaid LTSS beneficiaries are re-assessed at set intervals after placement and at least annually to determine whether they are receiving the appropriate level of services in the most appropriate setting. A level of care re-evaluation is conducted when the findings of the reassessment indicate that the beneficiary's needs have changed to such an extent that more intensive or specialized service options may be required.

B. The reassessments for LTSS beneficiaries receiving the NF level of care proceed in accordance with the following:

1. Change in scope of need -- Beneficiaries determined to have a high need for a NF level of care at the time of an annual reassessment or an assessment done in conjunction with a change in health status are deemed to have the highest need if they meet any of the needs-based criteria established for highest need in §§ 5.6.2 and 5.6.3 of this Part.

2. Periodic reassessment of highest need – At the time a determination of highest need is made for a beneficiary who opts to reside in a nursing facility, agency representatives evaluate whether there is a possibility that the beneficiary's condition may improve within the succeeding two (2) month period. Based on this information, the agency representative notifies the beneficiary, any authorized representative(s) and the nursing facility, that NF care has been authorized and that the beneficiary's functional and health status will be re-evaluated in thirty (30) to sixty (60) days. At the time of reassessment, the LTSS eligibility specialist reviews all available information about clinical and functional status to determine whether a change in level of need and/or service options is required.

5.6.7 Preadmission Screening/Resident Review (PASRR)

A. The PASRR is a federal requirement designed to: prevent the inappropriate placement of persons with serious mental or behavioral health conditions, intellectual disability or other developmental disability; and ensure that all NF applicants and residents regardless of payer source are identified, evaluated and determined to be appropriate for admission or continued stay and provided with specialized services (SS), if needed.

B. There are two levels to the PASRR:

1. Level I -- Completed prior to NF admission. The purpose is to identify: all NF applicants who possibly have developmental/ intellectual disabilities (DD/ID) and serious and persistent mental/behavioral health (MBH) conditions; and, on that basis, determine whether NF placement is appropriate and if Level II Preadmission Screening (PAS) (for specialized services) is warranted. An

assessment to determine if NF placement if appropriate must be done in accordance with the criteria set forth in 42 C.F.R. 483.132(a).

a. In Rhode Island, BHDDH retains control and responsibility for PASRR, while certain PASRR responsibilities are delegated to EOHHS. For all persons seeking admission to a NF without regard to payer, an EOHHS agency representative completes the PASRR Level I determination based upon information submitted by appropriately licensed or certified health care providers who are qualified by knowledge and/or experience in working with this population. BHDDH conducts all PASRR Level II evaluations, in consultation with EOHHS.

2. Level II -- The purpose of Level II is to comprehensively evaluate the need for specialized services persons found to be appropriate for NF placement. There are two types of level II evaluations -- one for new applicants and one for resident reviews conducted on an "as needed" basis or when a person receiving specialized services experiences a change in condition --

a. Pre-Admission Screening Determination (PAS). The state agency responsible must determine if an applicant has a physical and/or behavioral health condition that requires the NF level of care and if the NF is required to provide any specialized services to meet needs identified on the PAS. PAS determinations must be made in writing within an annual average of seven (7) to nine (9) working days of referral. If the applicant is seeking readmission to the NF due to an exempt hospital discharge (convalescent stay) that subsequently requires more than thirty (30) days of a NF level of care, a PASRR resident review is used and the determination must be conducted within forty (40) days of admission.

b. Resident Review (RR). The State agency with PASRR authority for each NF resident must determine whether he or she continues to have the highest need for the level of services provided by a NF and whether or not specialized services authorized during the PAS should continue. Resident reviews for persons with ID/DD are conducted periodically and upon significant change; and for persons with MBH conditions when there is a significant change unless it is an exempted hospital discharge or other categorical determination.

C. Under federal law, PASRR responsibilities are delegated as follows:

1. EOHHS -- The Medicaid single state agency is responsible for the following:

a. Ensures that all requirements of federal law are met;

b. Develops written agreements with the BHDDH, in its role as a PASRR authority;

c. Assures that the PASRR authorities fulfill their statutory responsibilities;

d. Oversees NF compliance with any assigned PASRR functions established by the BHDDH in level II evaluations;

e Requires that no person be admitted to a Medicaid certified NF without a PASRR level I PAS;

f. Ensures any specialized services determined necessary in the PASRR evaluation process are made available;

g. Notifies the NF resident related of the outcome of the PASRR determination and indicates whether specialized services are needed, the placement options available to the person, and appeal rights (See 42 C.F.R. §§ 483.130(k), 483.130(l)).

h. Provides a system of appeals for persons affected by any PASRR determination; and

i. Withholds Medicaid payment for any person who is living with a developmental disability or serious mental/behavioral health condition who is admitted to a NF without PASRR Level II or who remains in a NF contrary to PASRR rules.

2. BHDDH -- As the State's mental health authority, BHDDH retains control and responsibility for PASRR and must make timely level II evaluations. In addition, BHDDH ensures that all PASRR level II findings are issued in the form of a written evaluative report which is provided to the applicant/resident and their legal guardian, the admitting or retaining NF, the attending physician and where applicable the discharging hospital of the applicant or resident; and arranges for the provision of specialized services when appropriate in the NF setting or alternative placement option.

3. Nursing facilities -- NFs are responsible for the maintenance of all PASSR forms within a person’s record. In addition, to ensure documentation compliance, nursing facilities are required to maintain an active list of anyone within the PASRR MBH and DD/ID services. NFs must also:

a. Care planning. NFs must also consider the PASRR, other related assessments and treatment recommendations within the care planning process. During the resident’s annual care planning process, the nursing facility must complete a full assessment and care plan update for anyone receiving PASRR-related services.

b. Immediate need. When there is a significant change in a resident's condition, a NF is required to initiate treatment to meet immediate needs and then begin a comprehensive reassessment. Treatment is geared to

improvements when possible and prevention of avoidable decline, pending additional review and action by the State PASRR authorities. A comprehensive assessment must be completed by the 14th day after noting a significant change and the care plan must be revised accordingly within seven (7) days after its completion. The NF must also assure that any new or additional specialized services are provided pending a determination of whether a RR by the State is warranted during this twenty-one (21) day period.

c. Notice for Resident Review. If, upon completing an assessment and associated care plan update, the NF determines that a resident review is or might be necessary due to a significant change or other situation, the nursing facility must promptly provide LTSS clinical specialist and/or the BHDDH PASRR authority with proper written notification.

d. Interfacility Transfers. In cases of inter-facility transfers, the transferring NF is responsible for ensuring that PASRR evaluations accompany the resident when moved.

4. Specialized services for the NF population include:

a. Specialized Services for Behavioral Health Conditions

(1) Specialized services do not have to be provided by NFs. The term "Specialized Services" is equated with the level of care provided in psychiatric hospitals, or other intensive programs staffed with trained mental health professionals on a 24-hour/7-day basis. The patient's care follows the aggressive implementation of a treatment plan developed by an interdisciplinary team including a physician and other qualified mental health professionals and incorporates therapies supervised by these professionals. Treatment is aimed at diagnosing and reducing behavioral symptoms to improve the patient's level of functioning to a point that permits a reduction in intensity of services. While some of these services may be the same as those required to be provided by the nursing facility, it is the intensive level that sets these specialized services apart.

b. Specialized Services for Persons with Intellectual/Developmental Disabilities are provided in accordance with the following:

(1) Specialized services take the form of a continuous program of specialized and generic training, treatment, health care, and related services and supports that aggressively and consistently:

(AA) facilitates the acquisition of the behaviors necessary for the person to function with as much self-determination and independence as possible; and

(BB) promotes the prevention or deceleration of regression or loss of current optimal functional status. Specialized services do not include services to maintain generally independent beneficiaries who are able to function with little supervision or in the absence of a continuous specialized services program.

(2) BHDDH is responsible for the provision of specialized services that enhance the quality of life for persons with intellectual/developmental disabilities and maximize their potential for inclusion and participation in community life. The role of PASRR within this framework is to ensure and enhance the quality of care for persons with an I/DD who are residing in nursing facilities and to certify that a nursing facility is the most appropriate and least restrictive residential setting.

D. Exemptions to PASRR are identified in federal regulations at 42 C.F.R. §§ 483.100 through 483.138. In accordance with BHDDH's "advance group determination" wherein certain diagnoses and conditions that typically require NF admission are designated as exempt, the following classes are exempt from PASRR in Rhode Island: any person expected to be residing in a NF for less than thirty (30) days; any person in need of respite or emergency protective services; any person who has a terminal illness, severe or debilitating physical condition or illness, delirium, or dementia.

5.7 ICF/ID Needs-based Level of Care Determinations for Adults with Intellectual/Developmental Disabilities (IDD)

5.7.1 Overview

A. In Rhode Island, the Medicaid ICF/I-DD level of care is reserved for persons with developmental disabilities who meet the criteria established in Part 40-00-1 of this Title. Although there are licensed ICF/I-DD health institutions operating in Rhode Island, they are limited in number and open only to new applicants who require intensive and continuous skilled services in a highly restricted setting. Since the 1980s, the State has implemented a "community first" approach for adults with developmental disabilities who, were it not for access to HCBS, would require the level of care typically provided in an ICF/I-DD.

B. In accordance with the principles established in the Olmstead decision (Olmstead v. L.C., 527 U.S. 581), BHDDH has developed service options that encourage independence and self-direction, facilitate supportive employment, and provide the appropriate level of care. The service classifications established by BHDDH are

designed to ensure that the service options available to beneficiaries meet their needs in the least restrictive setting.

5.7.2 Assessments and Application of Needs-based Criteria

A. The BHDDH Division of Developmental Disabilities (DDD) is responsible for determining whether an applicant for Medicaid LTSS meets the level of care for DD services under the terms of an interagency agreement with the EOHHS. In determining level of care, DDD eligibility specialists consider whether an applicant meets the criteria established in State law with respect to developmental/intellectual disabilities. The needs of applicants who meet this definition are then assessed using a Supports Intensity Scale – Adult Version (SIS-A), the nationally recognized instrument of choice for assessing the scope of ID/DD level of need. In addition, BHDDH uses the Situational Assessment of Need (SAN) tool to evaluate the scope of supervision a beneficiary requires as well as any other associated risk factors relevant in and across service settings.

B. The SIS-A and SAN assessment instruments focus on different aspects of need:

1. The Supports Intensity Scale -- Adult Version (SIS-A) -- The SIS measures support requirements in 57 life activities and 28 behavioral and medical areas including, but not limited to, home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The assessment is conducted through an interview with the applicant and other persons who know the applicant well.

    a. Life activities. The SIS ranks each activity according to the frequency (refers to how often support is needed), amount (refers to how much time in one day another person is needed to provide support), and type of support (refers to what kind of support should be provided).

    b. Behavioral and medical health. The behavioral and medical section of the SIS-A rates exceptional medical and behavioral support needs.

    c. Supports Intensity Level (SIL). The SIL is determined based on the Total Support Needs Index, which is a standard score generated from scores on all the items tested by the Scale. These results are organized into service classifications -- "tiers" -- that correspond to level of need and the available service options.

2. Situational Assessment of Need (SAN) -- The SAN is used to determine if a person with high needs levels requires the 24-hour supervision of a group home or shared living settings by evaluating behavioral health and legal risk factors. If the results of the SAN demonstrate that the person requires 24-hour supervision, then the beneficiary may be offered the option of placement in a community group home or shared living setting. The service options available do not change with the new placement, however.

5.7.3 Service Classifications

A. The service classifications for Medicaid for LTSS for adults with disabilities are the tiers generated by the SIS assessment of needs levels.

1. Needs levels and associated tiers --The SIS assessment results are categorized as follows:

a. Tier A (High)- Qualifying Disability with mild support needs

b. Tier B (High)- Qualifying Disability with moderate support needs

c. Tier C (Highest)- Qualifying Disability with identified medical/behavioral needs requiring significant supports

d. Tier D (Highest)- Qualifying Disability with extraordinary medical issues requiring significant medical supports

e. Tier E (Highest)- Qualifying Disability with extraordinary behavioral issues requiring significant behavioral supports

2. Service classifications -- The State has established service classifications based on the SIS tiers:

a. Highest level of need. Tiers E, D and C:

(1) Tier E (extraordinary needs) -- Adults at this tier have extraordinary behavioral issues requiring significant behavioral supports including one-to-one supervision for at least a significant portion of each day. Many persons at this tier have a mental health condition in addition to a developmental disability and may pose a safety risk to themselves and/or the community without continuous on-site support.

(2) Tier D (extraordinary needs) -- Adults at this tier include persons with the most extensive/complex medical support needs that require nurse management to minimize medical risk factors. Maximum assistance with activities of daily living is required to meet their extensive physical support needs and personal hygiene; including lifting/transferring and positioning. Feeding tubes and other feeding supports (e.g., aspiration risk management), oxygen therapy or breathing treatments, suctioning, and seizure management are common as well. Persons at this needs level may be medically unstable or receiving hospice services.

(3) Tier C (significant needs) -- Adults at this tier have profound medical/behavioral needs requiring significant supports. Some

time may be spent alone, engaging independently in certain community activities and/or with natural supports.

b. High level of needs. Tiers B and A:

(1) Tier B (moderate needs) -- Adults at this level require more hours of daily support than those with needs at Tier A. Even though members of this tier have a broader scope of personal needs than those in Tier A, 24/7 supports are not required as their needs are still considered minimal in a significant number of life areas.

(2) Tier A (mild needs) -- Adults at this level are assessed as having mild support needs. Persons at this tier are capable of managing many aspects of their lives with limited supports and services. They do not require 24/7 paid supports as they are able to spend a significant amount of time on their own and/or engaging in the community with limited supports and services.

5.7.4 Service Options

A. Services in an ICF/I-DD health institution are reserved for beneficiaries determined to have the highest level of "extraordinary need" (Tier E) on the SIS who require intensive 24/7 care and, due to extenuating circumstances, may only be served in a highly restricted setting. Generally, medical conditions requiring continuous on-site skilled, rather than custodial care, prohibit applicants at this level from obtaining care in an HCBS setting. Persons with this level of need are served in an NF or LTH offering the same or a more robust service array.

B. The HCBS service options available to beneficiaries with the needs levels at each service classification provide the appropriate care and supports in the least restrictive setting. A summary of the service options available at each tier is as follows:

DD/ID Needs-Based Service Tier Classifications and Options		
Tier	Service Options	Available Supports
Tier D and E (Highest): Extraordinary Needs	Living with family/caregiver Independent Living Shared Living	Community Residential Support or access to overnight support services

	Group Home/Specialized Group Home Community Supported Living Services	Integrated Employment Supports Integrated Community and/or Day supports Transportation
Tier C (Highest): Significant Needs	Living with family/caregiver Independent Living Shared Living Group Home Community Supported Living Services	Community Residential Support or Access to overnight support services Integrated Employment Supports Integrated Community and/or Day supports Transportation
Tier B (High): Moderate Needs	Living with family/ caregiver Independent Living Shared Living Community Supported Living Services Group Home (Only an available service option when the	Integrated Employment supports Integrated Community and/or Day supports Access to overnight support services Transportation

	conditions set forth below in § 5.7.4 D are met).	
Tier A (High): Mild Needs	Living with Family/Caregiver Independent Living Community Supported Living Services Group Home (Only an available service option when the conditions set forth below in § 5.7.4 D are met). Shared Living (Tier A will have access to Shared Living services if they meet at least one defined exception).	Integrated Employment supports Integrated Community and/or Day Supports Access to overnight support services Transportation

C. Otherwise eligible persons who do not meet the needs-based criteria set forth above for the highest tier -- D and E -- may be placed in an alternative, more intensive care setting if certain special circumstances apply. In these situations, the scope of authorized supports remains tied to the tier associated with needs even though the setting has changed. Such circumstances include:

1. Loss of primary caregiver, such as hospitalization, debilitating illness, or death of spouse, caretaker sibling or adult child;

2. Loss of living situation, such as fire, flood, foreclosure, or sale of principal residence due to inability to maintain housing expenses;

3. A principal treating health care provider, or prior to ending an acute care hospital stay, a discharge planner indicates, based on a functional/clinical assessment, that the health and welfare of the applicant/beneficiary is at imminent risk if services are not provided or if services are discontinued;

4. The applicant/beneficiary met the highest level of care criteria on or before June 30, 2015 and chose to receive Medicaid LTSS at home or in a community-setting and the beneficiary reports he or she has experienced a failed placement that, if continued, may pose risks to the beneficiary's health and safety;

5. The beneficiary was admitted to a hospital or NF and is being discharged back to the original setting within any given forty (40) day period; or

6. There is a court order or other legal action requiring the provision of intensive supports or supervision that is only available in a residential supportive care setting.

5.7.5 Reassessments of the ICF/I-DD Level of Need

The BHDDH conducts reassessments of clinical and functional status at least annually and on an "as needed" basis. Unless these assessments warrant further review, redeterminations of clinical/functional eligibility and the level of need occur at five (5) year intervals.

5.8 Long-term Hospital Assessments and Level of Care Determinations

A. Long-term hospitals and the related HCBS alternatives serve people who may have one or more of a diverse set of clinical and/or functional needs. In addition, the intervals for re-determining level of care may differ depending on a beneficiary's acuity needs. Accordingly, both the process and criteria for determining the LTH level of need vary across agencies and populations as follows:

1. HCB Habilitative Care – EOHHS LTSS specialists determine the level of need for applicants and beneficiaries seeking home and community based habilitative services. The NF needs-based criteria set forth in § 5.6.3 of this Part apply. Applicants and beneficiaries with the high and highest need have the choice of obtaining Medicaid HCBS services in a community residential care setting or at home.

2. Under 21 psychiatric care – Medicaid applicants and beneficiaries up to age twenty-one (21) may obtain LTH services in a licensed psychiatric residential treatment center or a hospital under the authority of the Early, Periodic, Screening, Detection and Treatment (EPSDT) requirements of Title XIX and the Medicaid State Plan. Assessments center on "medical necessity" and clinical/functional need and are conducted by treating health practitioners, the Medicaid managed care plans, and/or the DCYF, if the child or young adult is participating in one of the department's programs.

3. Behavioral health services – The BHDDH and the State's Community Mental Health Centers assess the clinical and functional needs of applicants/beneficiaries with serious and persistent behavioral health conditions and/or mental illnesses. This assessment is used to determine:

a. Level of care. Whether the person requires the services and supports typically provided in an LTH to meet their clinical and functional needs;

b. Service classification. What the scope and intensity of the person's need for the LTH level of care are; and

c. Service options. Whether the person's needs can be met safely and effectively in the available HCBS alternatives, or require the more intensive services, supports, and supervision that can be accessed in a more restrictive health institution setting.

B. Reassessments are conducted annually or on a more frequent basis, depending on need. Redeterminations of functional/clinical eligibility occur no more than once annually, and less frequently for Medicaid LTSS beneficiaries who have clinical and/or functional limitations that are not expected to change.

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 00 - Long-Term Services

Involuntary Discharge from a Long-Term Care Facility (210-RICR-50-00-7)

7.1 Purpose and Overview

The purpose of this rule is to set forth requirements related to resident discharges and transfers initiated by state licensed long-term care facilities, without regard to the resident's source of payment. All such transfer/ discharges that are taken by a long-term care facility without the agreement or consent of the resident or the resident representative are involuntary and are prohibited, except as provided herein.

7.2 Legal Authority

A. State authorities: These rules are promulgated pursuant to the authority set forth in R.I. Gen. Laws Chapter 40-8, "Medical Assistance"; R.I. Gen. Laws Chapter 40-6, "Public Assistance Act"; R.I. Gen. Laws § 23-17-19.1, "Rights of Patients"; R.I. Gen. Laws Chapter 23-17.5, "Rights of Nursing Home Patients"; R.I. Gen. Laws § 23-17.5-17, "Transfer to Another Facility"; R.I. Gen. Laws Chapter 23-17.4, "Assisted Living Residence Licensing Act"; R.I. Gen. Laws § 23-17.4-16, "Rights of Residents."

B. Federal authorities: Additional authority is derived from 42 C.F.R. § 483 Subpart B, "Requirements for Long Term Care Facilities"; Title XIX of the Social Security Act; 42 U.S.C. § 1396r, "An Act to Amend Title XIX of the Social Security Act to Prohibit Transfers or Discharges of Residents of Nursing Facilities as a Result of a Voluntary Withdrawal from Participation in the Medicaid Program"; the State's Medicaid State Plan; and the Rhode Island Comprehensive Section 1115 Demonstration, as approved in final form on February 25, 2014, and as subsequently amended.

7.3 Definitions

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

1. "Assisted living residence" means a publicly or privately operated residence that provides directly or indirectly by means of contracts or arrangements personal assistance and may include the delivery of limited health services, as defined under R.I. Gen. Laws § 23-17.4-2(12), to meet the resident's changing needs and preferences, lodging, and meals to six (6) or more adults who are unrelated to the licensee or administrator,

excluding however, any privately operated establishment or facility licensed pursuant to R.I. Gen. Laws Chapter 23-17 and those facilities licensed by or under the jurisdiction of the Department of Behavioral Healthcare, Development Disabilities and Hospitals, the Department of Children, Youth, and Families, or any other state agency.

2. “Department of Human Services" or "DHS” means the State agency established under the provisions of R.I. Gen. Laws Chapter 40-1 that is empowered to administer certain human services. The DHS has been delegated the authority through an interagency service agreement with the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, to determine Medicaid eligibility in accordance with applicable State and federal laws, rules and regulations.

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

4. “Intermediate care facility for persons with intellectual/developmental disabilities" or "ICF/ID” means a State-licensed health care facility that provides long-term services and supports to persons with intellectual/developmental disabilities.

5. “Long-term care facility” means and includes nursing facilities (NF), assisted living residences (ALR), long-term care hospitals (LTH), and intermediate care facilities for persons with intellectual/ developmental disabilities (ICF-I/DD). Assisted living residences are also included for this rule only, although not licensed as health care facilities under R.I. Gen. Laws Chapter 23-17.

6. “Nursing facility” means an institutional setting that provides long-term care and is licensed in accordance with R.I. Gen. Laws Chapter 23-17, “Licensing of Health Care Facilities.”

7. “Resident representative” means any of the following:

> a. An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
>
> b. A person authorized by state or federal law (including but not limited to agents under power of attorney, representative payees,

and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;

c. Legal representative, as used in § 712 of the Older Americans Act (P.L. 114-144); or

d. The court-appointed guardian or conservator of a resident.

e. Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, state or federal law, or a court of competent jurisdiction.

8. “Transfer” or “discharge” means movement of a resident to a bed outside of the long-term care facility whether that bed is in the same physical plant or not. “Transfer” or “discharge” does not refer to the movement of a resident to a bed within the same long-term care facility.

7.4 Discharge Criteria

A. The long-term care facility must permit each resident to remain in the long-term care facility, and not transfer or discharge the resident from the long-term care facility unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the long-term care facility;

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the long-term care facility;

3. The safety of individuals in the long-term care facility is endangered due to the clinical or behavioral status of the resident;

4. The health of individuals in the long-term care facility would otherwise be endangered;

5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.

a. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.

b. For a resident who becomes eligible for Medicaid after admission to a long-term care facility, the long-term care facility may charge a resident only allowable charges under Medicaid; or

6. The long-term care facility ceases to operate.

B. Each long-term care facility must display a notice which identifies these transfer and discharge criteria and informs residents of their appeal rights. The notice should be prominently posted along with the Resident's Bill of Rights.

C. This information must be provided to the individual both verbally and in a prominent manner in writing on a separate page at the time of admission. A written acknowledgment of the receipt of the notice, signed by the individual must be obtained.

7.5 DOCUMENTATION REQUIREMENTS

A. In instances where a resident is being transferred or discharged, the long-term care facility must document in the resident's clinical record the basis for the transfer or discharge. The resident's physician must document as follows:

1. The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the long-term care facility;

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the long-term care facility;

3. The health of individuals in the long-term care facility would otherwise be endangered.

B. In instances of a resident's transfer, information provided to the receiving provider/facility must include a minimum of the following:

1. Contact information of the practitioner responsible for the care of the resident;

2. Resident representative information including contact information;

3. Advance Directive information;

4. All special instructions or precautions for ongoing care, as appropriate;

5. Comprehensive care plan goals;

6. All other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care.

7.6 PRE-TRANSFER/ DISCHARGE NOTICE

A. Before transferring or discharging a resident, a long-term care facility must notify the resident (and, if known, a resident representative) of the transfer or discharge and of the reasons for the discharge in a language and manner they understand. The long-term care facility must also notify the Office of the State Long-Term Care Ombudsman.

B. The written notice must include the following:

1. The reason for transfer or discharge;

2. The effective date of transfer or discharge;

3. The location to which the resident is transferred or discharged;

4. A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity that receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

5. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

6. For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities; and

7. For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder.

C. The long-term care facility must notify the resident at least thirty (30) days in advance of the resident's transfer or discharge.

D. At the time the resident receives the discharge notice, s/he must receive a notice of appeal rights.

E. Thirty (30) days advance notice is not required under the following circumstances:

1. In the event of danger to the safety or health of the individuals in the long-term care facility;

2. When the resident's health improves sufficiently to allow a more immediate transfer or discharge;

3. Where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs;

4. When the resident has not resided in the long-term care facility for a period of at least thirty (30) days.

5. In the case of such exceptions (as above), notice must be given as many days before the date of the move as is practicable, and include all of the information set forth in § 7.6(B) of this Part.

7.7 RESIDENT APPEAL RIGHTS

A. Long-term care facility residents who wish to challenge their transfers or discharges may appeal in accordance with the provisions of § 10-05-2.4.8 of this Title, “Appeals Process and Procedures for EOHHS Agencies and Programs.”

B. The appeals process cannot be limited to Medicaid-eligible long-term care facility residents. EOHHS will conduct administrative hearings for any long-term care facility resident who wishes to appeal a transfer or discharge from the facility, regardless of source of payment.

C. The long-term care facility may not transfer or discharge the resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the long-term care facility.

7.8 SEVERABILITY

If any provision in any section of this rule or the application thereof to any person or circumstances is held invalid, its invalidity does not affect other provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 00 - Long-Term Services

Medicaid Long-Term Services and Supports (LTSS) Post-Eligibility Treatment of Income (PETI) (210-RICR-50-00-8)

8.1 Overview

A. Medicaid LTSS beneficiaries are required by federal law and regulations, the State Plan, and the Section 1115 waiver to contribute income toward the Medicaid cost of care, irrespective of whether LTSS is provided in a health care institution or a home or community living arrangement. Only persons eligible for Medicaid LTSS on the basis of MAGI - the ACA adult expansion - are not required to pay toward the cost of care under federal regulations in effect as of March 1, 2018.

B. To ensure the beneficiary and/or spouse remaining at home (the "community" spouse) and the dependents of the LTSS beneficiary (the "institutionalized" spouse) have sufficient income and resources to thrive, Congress established a process to prevent spousal impoverishment. One important aspect of this process is a re-evaluation of the beneficiary's income - known as the post-eligibility treatment of income or "PETI" - to determine what, if any, amount remains and available to be applied to the LTSS cost of care after certain amounts are set aside or "protected" to meet the financial needs of the beneficiary, spouses and/or dependents. The amount a beneficiary must pay toward the cost of care for Medicaid LTSS coverage is referred to hereinafter as "beneficiary liability. This section pertains to the PETI process and the determination of beneficiary liability.

8.2 Legal Authority and Scope and Purpose

A. Federal Authorities:

1. Federal Law: Title XIX, of the federal Social Security Act at: 42 U.S.C. §§ 1396a, 1396b, and 1396k;

2. Federal regulations: 42 C.F.R. §§ 435.700 - 435.735; 435.800-435.832; 460.184, Parts I through G, including §§ 435.733, 435.735 and 484.10(e).

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

B. State Authorities: Among other statutes, R.I. Gen. Laws §§ 40-8, 40-8.9, and 40-8.10.

C. The PETI process is conducted by the State with verified information subsequent to the determination of income and resource eligibility, the assessment of clinical need and

the pre-authorization of services. Only the amounts set aside for the purposes set forth is in this rule may be protected. All the beneficiary's remaining income must be used to reduce the Medicaid payments for LTSS coverage. A beneficiary's income, protected amounts, and allocation to the cost of care are computed monthly to account for changes in income, the scope of services provided, and the cost of care, as appropriate.

8.3 Exclusions and Exemptions

A. There are certain beneficiaries receiving Medicaid LTSS coverage that are either excluded from the PETI or are exempt in certain circumstances, as indicated below:

1. Children and Youth Up to Age 19 - Children receiving Medicaid LTSS, irrespective of eligibility pathway, are not subject to PETI. Although there are some differences in the way beneficiary liability is determined by setting, the same general rules in this section apply irrespective of eligibility pathway or whether LTSS is provided in a health institution or at home or in the community.

2. SSI Beneficiaries - 1619(b) status - Irrespective of LTSS living arrangement, Medicaid beneficiaries who are working and have SSI 1619(b) status are exempt from the PETI process. Earned income is treated as invisible in the allocation process.

8.4 Definitions

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

1. "Authorized representative" means a person whom the applicant or beneficiary has designated to act on his or her behalf on matters related to LTSS Medicaid.

2. "Beneficiary liability" means the LTSS beneficiary's financial obligation toward the Medicaid LTSS cost of care, as determined monthly.

3. "Community spouse housing allowance" means the monthly housing allowance set by the federal government each year as the minimum amount that must be protected to cover the non-LTSS spouse's shelter expenses for his or her principal place of residence.

4. "Family allowance" means a deduction in the computation of a beneficiary's liability for the needs of dependent family members who are residing with the non-LTSS spouse or guardian.

5. "Family maintenance of needs allowance" means a deduction in the computation of beneficiary liability for the needs of dependent family members when there is no non-LTSS spouse and the dependent resided with the LTSS beneficiary immediately preceding the admission to a health care institution or LTSS community residence or is residing with the LTSS beneficiary at home.

6. "Family member" means a natural, adoptive, step-child, parent, or sibling of the LTSS beneficiary who is under age 19 and is claimed as a dependent by the LTSS beneficiary, non-LTSS spouse, or the couple for the most recent federal tax year, or, if a tax return was not filed, could be claimed as a dependent.

7. "Financially responsible relative" means a spouse or, if the person is a minor or older youth with a disability, the person's parent.

8. "HCBS maintenance needs allowance" means a required deduction in the income of a beneficiary liability to cover the costs of living needs of a Medicaid beneficiary requesting or receiving LTSS in a home or community-based living arrangement.

9. “LTSS beneficiary” means a person who meets all the general, clinical/functional, and financial eligibility requirements for LTSS, or a person receiving Medicaid LTSS of any type regardless of living arrangement. The LTSS beneficiary was previously referred to as the “institutionalized” individual.

10. “Maximum monthly maintenance of need allowance" means the amount established by the federal government as the maximum amount of income the State must protect to meet the maintenance of needs requirements of beneficiary’s spouse living in the community when determining beneficiary liability.

11. "Minimum monthly maintenance of needs allowance" means the amount established by the federal government as the minimum amount of income that the state must protect to meet the maintenance of needs requirements of beneficiary’s spouse living in the community when determining beneficiary liability. Based on 150 percent of the FPL for a family of two.

12. "Monthly spousal allowance" means the amount of a Medicaid LTSS beneficiary’s income that is set aside to meet the monthly maintenance of need expenses of a non-LTSS spouse.

13. “Non-LTSS spouse" means the spouse of an LTSS applicant or beneficiary regardless of LTSS living arrangement. It includes the spouses of anyone requesting or receiving Medicaid LTSS in a health care institution - NF, ICF-ID, or hospital - or in the home and community-based setting. When both spouses in a married couple are seeking or receiving Medicaid LTSS, neither is considered a non-LTSS spouse, irrespective of whether they reside together or separately.

14. "Personal needs allowance" means a required deduction in the computation of beneficiary liability for needs of the LTSS beneficiary and includes the federally mandated amount as well as State-only personal needs allowance, paid through the optional State supplement program.

15. "Service plan " means the scope of Medicaid LTSS, including the types of services to be furnished, the amount, frequency and duration of each service and the type of provider to furnish each service.

16. "Standard utility allowance" means an amount that is used in lieu of the actual amount of utility costs. The standard utility allowance is applicable if the non-LTSS spouse is responsible for payment toward the cost of gas, electric, coal, wood, oil, water, sewage, or telephone for the residence and is updated annually, in conjunction with the Supplemental Nutrition Assistance Program (SNAP) in the RI Department of Human Services' Administrative Code at 218-RICR-20-00-1.

8.5 Income for Post-Eligibility Purposes

A. PETI Income. During the post-eligibility review process, income is treated differently than during earlier steps in the LTSS eligibility sequence.

1. General Rules - The treatment and availability of income in the PETI is conducted in accordance with the following:

a. Only the income allocated to the LTSS beneficiary is considered available in the beneficiary liability determination.

b. During any month in which a Medicaid LTSS beneficiary is receiving covered services, the income of beneficiary's spouse is treated as unavailable.

c. In the case of an LTSS beneficiary who has no spouse, only the income of the beneficiary is considered in determining beneficiary liability.

d. Spouses separated by a continuous period of LTSS, regardless of living arrangement, are considered for PETI purposes to be living apart starting in the month the LTSS beneficiary begins to receive Medicaid LTSS.

2. Income Ownership - When determining the income ownership in the PETI process, the following rules apply and preempt any State laws that might otherwise govern community property or the division of marital property:

a. Non-trust property. Non-trust property is all property not subject to a trust. The instrument which provides income is reviewed to identify the specific provisions related to payment and the availability of income for the LTSS beneficiary and spouse. If the instrument providing the income lacks specific provisions relating to payment and availability of income, the following provisions apply:

(1) If payment of income is made solely in the name of the LTSS beneficiary or the spouse, the income must be considered available only to the spouse;

(2) If payment of income is made in the names of the LTSS beneficiary and the spouse, one-half of the income is considered available to each member of the couple;

(3) If payment of income is made in the name of the LTSS beneficiary, spouse or both, and to another person, the income is considered available to each spouse in proportion to that spouse's interest. If payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest is considered available to each spouse.

(4) In the case of income that is not derived from a trust in which there is no instrument establishing ownership, one-half of the joint interest is considered available to the LTSS beneficiary and one-half to the spouse.

b. Trust property. In the case of a trust, income is considered available to each spouse as provided in the trust or, in the absence of a specific provision in the trust, as follows:

(1) If payment of income is made solely to the LTSS beneficiary or the spouse, the income is considered available only to the spouse;

(2) If payment of income is made to both the LTSS beneficiary and the spouse, one-half of the income is considered available to each member of the couple;

(3) If payment of income is made to the LTSS beneficiary or the spouse, or both, and to another person or persons, the income is considered available to each spouse in proportion to the spouse's interest. If payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest is considered available to each spouse.

3. Rebutting Income Ownership --The provisions regarding non-trust property may be superseded to the extent that an LTSS beneficiary can establish, by a preponderance of the evidence that the ownership interests in income are other than as provided in this Part.

B. Recalculation of Income. The first step in the PETI process is the determination of gross income of the LTSS beneficiary by adding all earned and unearned income without including any disregards or exclusions that apply for eligibility purposes. Once gross

income has been established, federal law mandates that certain types of income must be excluded from gross income in the PETI calculation. They are as follows:

1. German reparation payments, Austrian social insurance payments, and Netherlands reparation payments, in accordance with the Nazi Persecution Victims Eligibility Act, Pub. L. No. 103-286 (20 C.F.R. § 416.1236(a)(18)); or provisions of the Austrian General Social Insurance Act, paragraphs 500 through 506.

2. Japanese and Aleutian restitution payments, under the provisions of section 105 of Pub. L. No. 100-383 (50a U.S.C. § 1989b et seq.) by persons of Japanese ancestry.

3. Agent Orange settlement payments under the provisions of the Agent Orange Compensation Exclusion Act, Pub. L. No. 101-201 (42 C.F.R. § 416.1236) received on or after January 1, 1989.

4. Radiation exposure compensation payments under the provisions of the Radiation Exposure Compensation Act, Pub. L. No. 101-426 (42 U.S.C. § 2210).

5. U.S. Veterans Administration pensions of up to the amount of ninety (90) dollars per month for LTSS beneficiaries residing in a health care institution (NF, ICF-ID, H). Applies to surviving spouses of veterans requesting or receiving Medicaid LTSS.

6. U.S. Veteran's Aid and Attendance (A&A) and housebound allowances (VHA) are reduced to and included in the $90 exclusion indicated in (5) above when residing in a health care institution. When the LTSS beneficiary is residing at home or in a community-based LTSS arrangement, the portion of the A&A or VHA payment allocated by the VA for room and board is excluded. The pension portion of the payment is included in the calculation of gross income and is considered when determining beneficiary liability unless specifically allocated for a spouse/ dependents. See: http://www.benefits.va.gov/pension/current_rates_veteran_pen.asp for pension amounts.

7. Seneca Nation Settlement Act of 1990 payments under the provisions of the Seneca Nation Settlement Act of 1990, Pub. L. No. 101-503 (25 U.S.C. § 1774) (as in effect January 1, 2014), received on or after November 3, 1990.

8. As indicated in § 8.3 of this Part, SSI cash benefits received under authority of Sections 1611(e)(1)(E) and (G) of the SSA (42 U.S.C. § 1382), Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 (42 U.S.C. § 1396a) are excluded for LTSS beneficiaries during the first three (3) full months of Medicaid LTSS in a health care institution. The EOHHS re-determines beneficiary liability retroactively if an SSI-eligible LTSS beneficiary's actual stay exceeds the expected stay of ninety (90) days or less.

9. Optional State Supplement Payments paid to LTSS beneficiaries residing in health care institutions. State supplement program cash assistance is as State-only payment that is considered to be a component of the beneficiary's personal needs allowance or HCBS special maintenance needs allowance and is identified herein as the State only personal needs allowance.

10. Payments received under the provisions of a State "Victims of Crime Program" for a period of nine months beginning with the month following the month of receipt.

11. Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al, per section 4735 of the Balanced Budget Act of 1997, Pub. L. No. 105-33 (42 U.S.C. § 1396u).

12. Payments made from any fund established pursuant to a class action settlement in the case of "Factor VIII or IX concentrate blood products litigation."

C. Sequence of Deductions. Once all required exclusions are applied, deductions are made in the income of the person seeking or receiving LTSS in a specific sequence. In general, the sequence functions as follows: the beneficiary's personal need allowance (identified as 1 through 2(b) in the table below), and then spousal and family allowances (3 and 4 in the table). If necessary, the personal needs allowance is adjusted to ensure that the allowances for spouses and family members are adequate. From this point forward, allowances for health costs, incurred expenses and, if appropriate, home maintenance are deducted. Both the nature of the deduction and the amount may vary by LTSS family structure and living arrangement:

Sequence of Deductions for PETI Allowances by Type		
Applicability by Setting		
Allowances	Institutional - NF, Hosp, ICF/ID	HCBS
1. Personal Need Allowance -federally mandated.	Yes For Non-Veterans total = $30	Yes
a. State Only -Personal needs allowance State-only	Yes	Yes -Amount varies by living arrangement
b. Veterans Improved Pension	Veteran LTSS beneficiaries in nursing facilities (NF) and other health care institutions only	No

Sequence of Deductions for PETI Allowances by Type		
Applicability by Setting		
Allowances	Institutional - NF, Hosp, ICF/ID	HCBS
c. Therapeutic Employment (TE) - Personal needs allowance	Yes	No
2. HCBS - Maintenance of Needs Allowance for the LTSS beneficiary, OR:	No	Yes
a. Intellectual and Developmental Disabilities - Special Maintenance Needs Allowance	No	For LTSS beneficiaries participating in the Medicaid HCBS habilitation program and integrated community employment support program for persons with developmental disabilities. See § 8.6(B)(4) of this Part
b. Assisted Living - Special Maintenance Needs Allowance - Assisted/Supported Living	No	For LTSS beneficiaries. See § 8.6(B)(3) of this Part
3. Monthly Spousal Allowance - Amount protected for a beneficiary's spouse	Yes	Yes
4. Family Allowance - Dependent family members when there is a non-LTSS spouse; OR	Yes	Yes
Family Maintenance of Need - Dependent family members, when	Yes	Yes

Sequence of Deductions for PETI Allowances by Type		
Applicability by Setting		
Allowances	Institutional - NF, Hosp, ICF/ID	HCBS
there is NO non-LTSS spouse		
5. Health Coverage and Expenses	Yes	Yes
6. Special Incurred Expenses - including legal guardianship fees	Yes	Yes
7. In Institution - Time Limited Home Maintenance Allowance	Yes	No

D. PETI Standards - When determining the amount of an allowance in the PETI process the following standards apply:

PETI Allowance Standards	
Standard	Monthly Amount and Basis
Personal needs allowance standard	Non-veterans = total federal minimum plus and State supplement program payment ($50) Veterans = improve pension ($90)
Therapeutic employment personal needs allowance	An additional $85 plus one-half of earned income allowance, after deducting certain employment expenses and fees.
Minimum Monthly Maintenance of Need Allowance -- for non-LTSS spouse	Based on 150% of the FPL for a family of two -
Community Spouse Housing Allowance	Amount established by the federal government and the standard utility allowance for SNAP
Home and Community-Based Services - Maintenance of Needs Allowance	100% of the FPL for one + $20

PETI Allowance Standards	
Standard	Monthly Amount and Basis
State only personal needs allowance for beneficiaries receiving the optional State supplemental payment to SSI	Varies by living arrangement
Assisted Living Special Maintenance of Need Allowance -- beneficiaries eligible for State supplement payment	Federal Benefit rate + State supplement payment for Category D or F, less State only - personal needs allowance, adjusted for single v. double room -- For beneficiaries with income up to 300% of the SSI income standard
I/DD-Special Maintenance of Needs Allowance - habilitation and developmental disabilities programs	HCBS maintenance of need allowance (100% of the FPL and a $20 standard disregard) plus any earned income not to exceed 300% of the SSI income standard
Family Allowance	One-third of the minimum monthly maintenance needs allowance per dependent family member
Family Maintenance of Need	Medically needy income limit adjusted for family size. Medicaid LTSS beneficiary living with family members is included in family size. LTSS Medicaid beneficiaries residing in institutional living arrangements are NOT included in family size
Health Coverage and Expenses	Actual costs but only if not paid for or reimbursed by Medicaid or a third-party and allowable expenses otherwise not covered by Medicaid, including Medicare and other health insurance premiums
Special Incurred Expenses	Within applicable limits See § 8.6(A)(2)(b) of this Part
In Institution - Time Limited Home Maintenance Allowance	Up to 100% of the FPL for one per month, based on expenses, for no more than six months

8.6 Personal and Family Maintenance of Need Allowances

A. Personal Needs Allowances. In general, LTSS beneficiaries receiving services in a health care institution receive a monthly personal needs allowance to cover the costs of daily needs that are not covered by the facility such as grooming, reading materials, cell phone fees and the like. A personal needs allowance is also provided to LTSS

beneficiaries living in community settings such as Medicaid-certified assisted living residences under certain circumstances - that is, when eligible to receive the optional State supplement payment for low-income beneficiaries. The amount of the personal needs allowance is also a function of whether the LTSS beneficiary was receiving a pension from the Veterans Administration and has no spouse or dependents or qualifies as a surviving spouse.

1. Personal Need Allowance - A personal needs allowance is provided to LTSS beneficiaries who reside in a health care institution. (The maintenance of need allowances set aside for Medicaid LTSS beneficiaries residing in certain HCBS living arrangements are set forth in paragraph (3) below). The personal needs allowance amounts indicated below include optional State supplemental payments as well as required federal amounts, except as provided for veterans:

a. Monthly Personal Needs Allowance of $50. LTSS beneficiaries residing in a NF, ICF-ID, or hospital providing long-term services receive a personal needs allowance of $50. The personal needs allowance consists of a mandated federal allowance of $30 and the State only - personal needs allowance through State supplement payment of $20 per month.

b. Veterans Personal Needs Allowance of $90. The Veterans Benefit Act of 1992 entitles veterans who had received a pension to obtain what is known as the "veteran's improved pension" of $90 per month when residing in a health care institution. This $90 benefit is treated as a personal needs allowance and is deducted from income when determining liability for veterans who are Medicaid LTSS beneficiaries. The $90 veteran's improved pension is available to Medicaid LTSS beneficiaries who are veterans and do not have a spouse or dependent child; or are the surviving spouse of a veteran who does not have a dependent child(ren). The improved pension is provided instead of the $50 monthly personal needs allowance for non-veteran Medicaid LTSS beneficiaries.

2. Expanded - Personal Needs Allowance - The personal needs allowance of LTSS beneficiaries may be expanded in certain circumstances as indicated below:

a. Therapeutic Employment - Personal Needs Allowance. LTSS beneficiaries may retain a higher personal needs allowance if they have earned income as result of therapeutic employment. The personal needs allowance is deducted from the total amount of earned income related to public or private employment. To be considered therapeutic, the employment must be part of a written plan developed by the Office of Rehabilitative Services, of the Department of Human Services, or a similar entity and be for the purpose of enhancing the beneficiary's ability to achieve the highest level of independence. For these beneficiaries, the therapeutic employment - personal needs allowance is an additional $85 plus one-half (1/2) the remainder of earned income per month, subsequent to deducting actual FICA tax withheld, transportation costs, employment

expenses, such as tools and uniforms, and State and federal taxes if the person is not exempt from withholding. The total may be protected for personal needs. The maximum therapeutic employment - personal needs allowance will vary but may not exceed $400 per month. See below for the expanded HCBS special maintenance needs allowance for employed LTSS beneficiaries with developmental disabilities residing at home.

b. Allowable fees. LTSS beneficiaries who incur expenses related to a guardianship or conservatorship, legal fees and/or tax assessments, court-orders or other legally binding instruments may receive an expanded personal needs allowance, or in the case of attachments or liens, a pre-emptive allowance to cover associated costs or legal obligations in certain circumstances when appropriate documentation is provided:

(1) Guardianship/conservatorship. LTSS beneficiaries who have court-appointed guardians or conservators are allowed an expanded personal needs allowance to pay for certain court-approved or ordered fees. To be considered, the expense must be required for the LTSS beneficiary to make income or resources available, or to gain access to or consent for necessary medical treatment if the LTSS beneficiary does not have the capacity to make decisions on his or her own.

(2) Requests and documentation - probate order and itemized bills - are reviewed by the EOHHS legal team and LTSS specialists. The total amount allowed must be reasonable based on applicable rates and fee schedules approved by the RI Supreme Court. Monthly deductions of up to one hundred twenty-five dollars ($125) may be allowed for guardianship expenses. Monthly deductions up to one hundred twenty-five dollars ($125) may also be allowed for related legal fees. An additional deduction from income of up to two hundred fifty dollars ($250) is recognized for allowable expenses related to a guardian-ad-litem during the month in which the LTSS beneficiary pays the expense.

(3) Legal Fees. LTSS beneficiaries who incur fees resulting from legal action to obtain income or resources for their support may retain income in the form of an expanded personal needs allowance to pay such fees. The maximum which may be deducted from income is the lesser of the actual fee, or one third of the settlement amount.

(4) Tax Assessments. LTSS beneficiaries ordered by the federal Internal Revenue Service, the Rhode Island Department of Revenue or other State or municipal taxing authority to pay income taxes may retain an expanded personal needs allowance or a lump-sum of income for such purposes.

(5) Legal Attachments or Obligations. LTSS beneficiaries who are court-ordered to pay all or a portion of income to address an outstanding debt, or obligation such as spousal or child support, receive an expanded personal needs allowance equal to the amount due to meet that court ordered monthly obligation. The allowance may also be based on the terms of a settlement agreement that, although not court ordered, is legally binding. In instances in which this allowance absorbs all income, the State reviews the applicable legal documentation before proceeding with the cost of care calculation.

B. Home and Community-Based Services Maintenance of Need Allowance. Medicaid LTSS does not cover room and board when provided in a home or community-based living arrangement. To ensure LTSS beneficiaries opting for care in these settings have adequate resources to meet these and other person need expenses, a maintenance of need allowance has been established for those receiving HCBS. LTSS beneficiaries in HCBS living arrangements may qualify for the HCBS maintenance needs allowance only, a State-optional (SO) personal needs allowance and HCBS maintenance needs allowance, or special maintenance of need allowance based on setting or LTSS need addition to non-LTSS spousal and family allowances or a family maintenance of need allowance:

1. HCBS Maintenance Needs Allowance Only - The HCBS maintenance needs allowance is set at 100 percent of the FPL plus a $20 personal needs allowance, for a family of one, and is taken as a deduction from the Medicaid LTSS beneficiary's gross income subsequent to any required exclusions. Beneficiaries who qualify for the State optional supplement receive an additional payment, as indicated below. Although the HCBS maintenance needs allowance is protected income that cannot be included in the calculation of beneficiary liability, the income is available for room and board, personal effects, and any attendant health costs that are not covered by Medicaid. The HCBS maintenance needs allowance is based on a reasonable assessment of need provided in lieu of a home maintenance allowance, unless statutory requirements direct otherwise.

2. State Only - Personal Needs Allowance - R.I. Gen. Laws § 40-6-27 establishes the State's optional supplemental payment and requires that a portion of the monthly cash payment provided to LTSS beneficiaries who are residing in certain living arrangements be set aside as a State-only personal needs allowance. Only beneficiaries with income at or below 300 percent of the SSI standard are eligible for this deduction. This State only - personal needs allowance is in addition to the HCBS maintenance needs allowance and varies in accordance with the State supplement payment category and/or type of residence:

a. Living in own household -- $39.92 for an individual and $79.36 for a couple

b. Living in the household of another -- $51.92 for an individual and $97.30 for a couple

c. Medicaid certified assisted living residence, State supplement payment Category D - $100 SPNA

d. Community Supportive Living Program residences, State supplement payment Category F - $120 SPNA

e. Medicaid beneficiaries who qualify for Category D, but do not meet the eligibility requirements for long-term care, receive a State only- personal needs allowance of $55.

3. Assisted Living -Special Maintenance Needs Allowance -- LTSS beneficiaries who qualify for the State supplement payment and reside in a Medicaid certified assisted living residence receive a set assisted living - special maintenance needs allowance which is equal to the federal benefit rate (FBR) for one plus the State supplement payment, less the state only - personal needs allowance. The amount of the assisted living - special maintenance needs allowance varies depending on whether the residence is certified to provide LTSS to beneficiaries with needs that qualify for State supplement payment in assisted living residences (Category D) or community supportive living arrangements authorized to provide enhanced/specialized services (Category F). (Category F includes assisted living residences licensed by the state to provide these enhanced/specialized services.)

4. All income above the assisted living - special maintenance needs allowance, less the applicable personal needs allowance, that is not allocated to a spouse or dependent is available to pay the cost of care, including the pension portion of Veteran's Administration Aid & Attendance payments. LTSS beneficiaries who do not qualify for the State supplement payment are treated as if they were living at home and are subject to § 8.6(B)(1) of this Part, related to HCBS maintenance needs allowance above unless they have a spouse, in which case § 8.6(C) of this Part below also applies. The HCBS maintenance needs allowance is protected and allocated to room and board, except for the personal needs allowance of $100. All remaining income is available to pay toward the cost of care. The State supplement payment is reduced by the non-pension portion of Aid & Attendance, which must be allocated for room and board or toward the spousal allowance:

a. The Assisted Living - Special Maintenance Needs Allowance LTSS Beneficiary-Category D. The assisted living - special maintenance needs allowance for a single room is $982 and for a double room is $857 after the State only - personal needs allowance of $100 is deducted.

b. The Assisted Living - Special Maintenance Needs Allowance LTSS Beneficiary-Category F. The assisted living - special maintenance needs allowance is $1,427 for a single room and $1,141 for a double room after the State only personal needs allowance of $120 is deducted.

5. Intellectual/Developmental Disabilities -Special Maintenance Needs Allowance - LTSS beneficiaries participating in the RI Department of Behavioral Healthcare,

Developmental Disabilities and Hospitals (BHDDH) Development Disabilities (DD) Program or the EOHHS Habilitation Program who are employed are eligible for the intellectual/developmental disabilities - special maintenance needs allowance and an additional amount of earned income up to but not exceeding 300 percent of the SSI income standard.

6. Exceptions - A beneficiary may receive an allowance that is above the maintenance of need allowance set by the State when:

a. Court-ordered. A court-order may require the allocation of a different portion of the beneficiary's income to a spouse or a dependent as indicated in § 8.6(A)(2)(b)(5) of this Part; or

b. EOHHS Hearing Decision. Upon presenting evidence of hardship in an EOHHS administrative fair hearing, the maintenance of need allowance for a beneficiary living at home may be increased if the amount provided is insufficient based on a reasonable assessment of need, as is required in 42 C.F.R. § 435.735(c)(1). Such an assessment must consider evidence that pertains directly to a beneficiary's need to maintain shelter including, but not limited to, rent or mortgage payments, property related taxes, fees and/or insurance, and utility costs. Hardships affecting home stability resulting from natural or human-made disasters such as a fire, weather damage, criminal acts may also be considered. The HCBS maintenance needs allowance increase may not exceed the minimum monthly maintenance of needs allowance in any given year.

C. Monthly Spousal Allowances. The monthly spousal and family allowances are the principal mechanisms for assuring that the dependents of an LTSS beneficiary do not become impoverished as a result the obligation to pay income toward the Medicaid cost of care. The method for determining what type of spousal and family allowance and the amount also varies depending on family structure and living arrangements.

1. Monthly Non-LTSS Spousal Allowance - In instances in which the LTSS beneficiaries is married and the spouse is not requesting or receiving Medicaid LTSS, the monthly spousal allowance is established by:

a. Determining gross income of the spouse. The gross income of a non-LTSS spouse is the total of earned and the unearned income, without applying the disregards and exclusions used when determining income eligibility.

b. Calculating shelter costs. The shelter costs for maintaining the household of a non-LTSS beneficiary's principal place of residence are calculated by adding together monthly rental or mortgage payments (principal and interest), taxes and insurance, condominium or cooperative

required maintenance charges, and the standard utility allowance, as applicable. The minimum is the Community Spouse Housing Allowance set annually by the federal government.

c. The standard utility allowance. The standard utility allowance, as updated annually in 218-RICR-20-00-01 of the DHS Administrative Code for SNAP, serves as a proxy for utility costs when calculating shelter costs without respect to actual costs incurred by a non-LTSS spouse. This allowance is only included in the computation of shelter costs if the non-LTSS spouse is responsible for paying such expenses.

d. Excess shelter allowance. To determine the excess shelter allowance, the sum of all shelter costs is deducted from the minimum monthly maintenance of need allowance. Any expenses above the standard constitutes the excess shelter allowance and is added to the minimum monthly maintenance of needs allowance and the determination proceeds as follows:

(1) If there is no excess shelter allowance or the sum of the excess shelter allowance and the minimum monthly maintenance of needs allowance are at or below the standard minimum allowance standard established for the year, the minimum monthly maintenance of needs allowance is used as the basis for determining the monthly spousal allowance.

(2) If the sum of the excess shelter allowance and minimum monthly maintenance of needs allowance are above the standard but below the maximum monthly maintenance of need allowance, then the sum serves as the basis for determining the monthly spousal allowance.

(3) If the sum of the excess shelter allowance and minimum monthly maintenance of needs allowance is at or above the standard maximum allowance, the maximum monthly maintenance of need allowance serves as the basis for determining the monthly spousal allowance.

e. Monthly Spousal Allowance. To determine the monthly spousal allowance, the non-LTSS spouse's gross income is deducted from the sum of the excess shelter allowance and minimum monthly maintenance of needs allowance. The monthly spousal allowance is the amount remaining after this calculation and determines the amount of the LTSS beneficiary's income that is protected - available to the spouse - to meet the spouse's monthly needs and, as such cannot be included in the calculation of the LTSS beneficiary's liability toward the cost of care.

f. Exceptions. A non-LTSS spouse may obtain a monthly spousal allowance that exceeds the maximum monthly maintenance of need allowance standard when:

(1) Court-ordered. A court-order may require the allocation of a larger portion of the beneficiary's income to the spouse; or

(2) EOHHS Hearing Decision. Upon presenting evidence of hardship in an EOHHS administrative fair hearing, the monthly spousal allowance may be increased in certain circumstances.

2. No Monthly Spousal Allowance - If a Medicaid LTSS beneficiary does not have a spouse, there is no monthly spousal allowance regardless of LTSS living arrangement. Certain family allowances may apply however.

D. Family Allowances. The Medicaid LTSS beneficiary's income may be reduced by deductions for dependent family members. There are two types of family allowances that apply depending on whether there is a non-LTSS spouse. If there is a non-LTSS spouse, a family allowance is provided in addition to the monthly spousal allowance; if there is no spouse, a family monthly maintenance of need allowance is calculated. The family maintenance of needs allowance varies depending on whether the Medicaid LTSS beneficiary is residing with family members.

1. Family Allowance (FA)- A family allowance is determined when there is a non-LTSS community spouse residing with family members who are the dependents of the spouse or the LTSS beneficiary. The LTSS living arrangement of the beneficiary is not a factor in determining whether this allowance applies. The family allowance is the sum total of the allowances determined separately for each family member as follows:

a. Determination of gross income. The earned and unearned income for each family member is calculated without any disregards or exclusions.

b. Family allowance standard. The minimum monthly maintenance of needs allowance standard is multiplied by one-third. The result of this computation is the family allowance standard that applies when determining the allowance for each family member.

c. Individual family member's allowance. The gross income of each family member is subtracted from the family allowance standard. The amount remaining from this calculation is the family allowance for that family member

d. Total Family Allowance. The individual allowances for each family member are added together to determine the total family allowance. The family allowance counts toward the maximum MMN allowance.

2. Family maintenance of need allowance - When the Medicaid LTSS beneficiary does not have a spouse, a family maintenance of need allowance is established that provides for a broader range of expenses than are considered when there is a monthly spousal allowance. This family maintenance of needs allowance is calculated in accordance with the following:

a. Determination of gross income. The earned and unearned income for each family member is calculated without any disregards or exclusions.

b. Family maintenance of need (FMN) standard. The gross income of each family member is added together and deducted from the FMN standard, which is the medically needy income limit based on family size.

(1) If the Medicaid LTSS beneficiary resides with family members in a HCBS living arrangement, he or she is included in the family when determining family size;

(2) If the Medicaid LTSS beneficiary is in a health care institution or does not reside with family members, family size is based on the number of family members only - that is, the LTSS beneficiary is not counted.

c. Family maintenance of needs allowance. The difference between the family maintenance of need standard and total gross income of the family members is the family maintenance of need allowance. The family maintenance of needs allowance counts toward the maximum monthly maintenance of need standard.

8.7 Health Expenses

A. Health care and insurance. Additional amounts of the income of a Medicaid LTSS beneficiary may be protected to cover certain medical/health costs incurred by the beneficiary or financially responsible relatives, such as spouse, sibling, or adult child.

1. Health Coverage Costs - Health care premiums, co-payments and deductibles incurred by the Medicaid LTSS beneficiary that are not subject to payment by Medicaid or a third party may be deducted from income. This includes the beneficiary's costs for Medicare, including Medicare Advantage and Part D plans, supplemental health insurance for dental and/or vision and long-term care insurance policy premiums. Only the portion of these costs that is for the Medicaid beneficiary are allowed.

2. Allowable Medical Expenses - Unpaid past expenses for medically necessary services may be deducted from available income in certain circumstances. For such expenses to reduce available income for beneficiary liability determination purposes, they must meet all the criteria to be considered allowable and exclude any costs of care already used to meet the beneficiary's spenddown. A medical

expense must be allowable under this section to be deducted in the LTSS income calculation. An allowable expense must meet the following conditions:

a. Medically necessary. The expense must be medically necessary. A necessary medical expense is an expense rendered --for any of these situations:

(1) In response to a life-threatening condition or pain;

(2) Treat an injury, illness or infection;

(3) Achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition;

(4) Provide care for a mother and child through the maternity period;

(5) Prevent the onset of a serious disease or illness;

(6) To treat a condition that could result in physical or behavioral health impairment; or

(7) When such services are provided or ordered by a licensed health care professional or provider they are presumed to be medically necessary. In instances when such services are provided by some other person or entity, documentation of medical necessity may be required.

b. Non-Medicaid Service. The expense must not be covered by Medicaid. An expense cannot be deducted if it is a Medicaid-covered service and is incurred in a month in which eligibility may exist, including the month of application and the retroactive eligibility period. Exceptions are granted for Medicaid covered services only if the health costs were incurred for a medically necessary service provided prior to the retroactive eligibility period and are a legally binding debt obligation or attachment or lien as indicated in § 8.6(A)(2)(b) of this Part. In addition:

(1) An expense incurred in a month for which eligibility is approved is presumed to be a Medicaid covered service unless the applicant provides documentation that it is not.

(2) When an applicant for LTSS is receiving a service or set of services Medicaid pays for in a daily or bundled rate, the items and services included in that rate are not separate allowable expenses whether provided in an institution, such as a NF or hospital, or home and community-based setting, such as a DD group home, assisted living residence, etc.

c. No Thirty Party Payment. An allowable expense must not be eligible for payment by a third party. For these purposes, a third party could be individuals, entities or benefits that are, or may be, liable to pay the expense including, but not limited to: other health care coverage, such as coverage through Medicare, private or group health insurance, long-term care insurance or through the Veterans Administration (VA) health system; automobile insurance; court judgments or settlements; Workers' Compensation.

d. Allowed Expense Period. The expense must be incurred during a month in which the applicant/beneficiary is receiving Medicaid-funded LTSS or the retroactive period unless the exception for legally binding debt or attachments apply. The first day of the month an application for LTSS is filed, or a request for review of an expense is submitted is the start date for determining whether an expense qualifies, regardless of whether retroactive coverage is requested or approved.

(1) An expense incurred during the three (3) month retro-period must be unpaid as of the date the agency received the request, unless it was incurred in a month that Medicaid LTSS coverage was active.

(2) An expense incurred while Medicaid LTSS is active may be paid or unpaid.

3. Limits -- If all of the above conditions apply, the expense may still not be allowed in certain circumstances:

a. Expense in penalty period. An expense cannot be deducted for an LTSS service incurred during a penalty period in due to an uncompensated transfer. However, non-LTSS expenses, such as primary, acute or subacute care services incurred during a period of ineligibility, may be an allowable expense if all other conditions are met.

b. Used for other reductions. The expense must not have been treated as or paid:

(1) To reduce excess resources -- an expense paid by an applicant to meet resource eligibility limits cannot be deducted in the income calculation.

(2) As an income exclusion or deduction -- an expense previously used as a deduction in the income calculation cannot be used under this section.

4. Charges Not Allowed -- Under current federal regulations, the following services are not allowable expense deductions when provided to a Medicaid applicant:

a. Personal Items. Items such as shampoo, toothpaste or dental floss;

b. Elective or Expanded Services. Optional or elective features to services and supports that are not medically necessary, such as a motorized wheel chair, prescription sunglasses, elective treatments or procedures for non-medical purposes;

c. Provider travel. A charge for a provider to travel to an applicant's residence when no medical service is provided.

5. Deduction Timeline -- Allowable expenses are deducted in the LTSS income calculation for the month in which the expense is incurred. Expenses that were incurred in the three (3) months prior to the month the request for payment of LTSS services is submitted can be deducted beginning in the first month of eligibility.

6. Excess Carryover --The excess amount of an allowable expense can be carried forward and used as a deduction in future months when the amount of the expenses combined exceeds the amount of income remaining after all other deductions.

8.8 Institutional Limited Home Maintenance Allowance

A. A home maintenance allowance is available for either a single LTSS beneficiary, in addition to the personal needs allowance, when residing in a health care institution and if there is an intent to return home. The allowance is equal to up to 100 percent of the FPL for a family size of one. The home maintenance allowance counts toward the maximum monthly maintenance of standard.

1. Access to the Home Maintenance Allowance - To obtain the home maintenance allowance, the following conditions apply:

a. Time limits. The deduction from income resulting from the home maintenance allowance cannot be allocated for more than six (6) months in any continuous period of Medicaid LTSS in a health care institution.

b. Certification. A licensed physician must certify that either LTSS beneficiary or both are likely to return to the home during the six-month period. The allowance ceases once a beneficiary is discharged and returns to the home.

c. Home Expenses. The LTSS beneficiary or beneficiaries has expenses that are required to maintain a residence (owned or rented) in the

community including, but not limited to, taxes, rent, mortgage payments, utilities, and insurance; and

d. Other Resident Family Members. A spouse, dependent child or other person who is or could be claimed as a dependent for federal income tax purposes was not residing in the home at the time the beneficiary was admitted to the LTSS health care institution; or, if both spouses are LTSS beneficiaries, they were admitted to a health care institution on the same day.

2. Application of the Allowance -- In instances in which LTSS beneficiaries qualify for the home maintenance allowance, it must be provided as follows:

a. One beneficiary only. The allowance is deducted from the income of only one LTSS beneficiary, even in cases in which both members are receiving Medicaid coverage in a health care institution. The determination of which spouse will receive the home maintenance allowance is based on an assessment of what is most advantageous to both members of the couple.

b. Restrictions. A Medicaid LTSS beneficiary residing in a health institutional arrangement is prohibited from receiving the home maintenance allowance and for the support of dependents at home.

8.9 Determination and Collection of Beneficiary Liability

A. PETI income is the amount of an LTSS beneficiary's income that is applied to the LTSS Medicaid cost of care after the deduction of all available allowances. If the beneficiary's gross income is depleted by the allowances deducted - PETI income is $0 - there is no beneficiary liability and no payment toward the Medicaid cost of care is required.

1. Agency Responsibilities - In determining and applying PETI income for beneficiary liability purposes, the agency has the following responsibilities:

a. Calculation of beneficiary liability. In general, the determination of beneficiary liability is based on the income and resources of the applicant beginning on the eligibility date, which is the first day of the month in which an application is filed and date stamped as received by the agency. There is no beneficiary liability for services covered during the ninety-day retroactive period which begins in the month prior to the filing of the application.

b. Collection date. The obligation to pay beneficiary liability varies by type of LTSS when eligibility is determined by the State in a month after the application is filed irrespective of the eligibility date as follows:

(1) HCBS beneficiaries - Beneficiary liability begins on the first day of the month in which a determination of eligibility is made. If eligibility is determined in a month after the application was filed, beneficiary liability does not accrue retroactively back to the eligibility date, however. Therefore, collection of beneficiary liability for HCBS beneficiaries is always prospective and begins on the first day of the calendar month after eligibility is determined by the state.

(2) NF and other health institutions. LTSS beneficiaries residing in health institutions are obligated to pay what they can afford toward the cost of care beginning on the date of admission. Accordingly, for beneficiaries who were residing in such institutions on the date the application was filed, liability toward the cost of care begins on the eligibility date - the first day of the month in which an application is filed - irrespective of the date eligibility is actually determined by the State. Thus, beneficiary liability does accrue retroactively for LTSS beneficiaries residing in health care institutions.

c. Reductions. In instances in which the LTSS applicant has no spouse or dependents and has incurred LTSS costs during the period an application is pending, liability for the cost of care may be reduced for the first month to take these additional costs into consideration.

d. Adjustments. In general beneficiary liability must be recalculated at any time there is a change in a factor that was used as the basis for an allowance including, but not limited to, the death of the non-LTSS spouse, sale of a home, change in living arrangement, income, or scope of benefits. Beneficiary liability is also adjusted prospectively, even in situations in which a beneficiary did not make a timely report of such a change. The only exceptions to prospective adjustments are as follows:

(1) Partial month eligibility. Beneficiary liability is adjusted when a LTSS beneficiary receives services for less than a full month due to death, discharge, or change in LTSS living arrangement, such as nursing facility to home.

(2) Beneficiary Overpayments. Retroactive adjustments are made when an agency system error resulted in an overpayment liability by a beneficiary for one month or more. The adjustments date back to the first of the month when the error was made. Retroactive adjustments are NOT made when beneficiary liability is understated.

e. Notice. Beneficiary liability may not be imposed without first providing prior notice to the beneficiary indicating the amount of the monthly

payment and appeal rights. This requirement applies at the time of the initial eligibility determination in the benefit decision notice and Medicaid LTSS renewals as well as at any time there is reassessment of need indicating a change in living arrangement is required, such as the beneficiary no longer has the highest need for a NF level of care.

f. Provider notification. Notification is provided to the health care institution or HCBS provider if there are any changes to beneficiary liability.

2. Beneficiary Responsibilities - To ensure beneficiary liability is implemented in a fair and accurate manner, the LTSS beneficiary must:

a. Payment. The LTSS beneficiary must pay beneficiary liability in the amount required to the provider in accordance with § 8.9(A) of this Part unless specifically notified otherwise. Upon confirming that a beneficiary has failed to make payment for three (3) consecutive months, the State may take action to resolve the debt or terminate services. Prior to taking an action, the State issues a notice informing the beneficiary that Medicaid-funded HCBS will be terminated in thirty (30) days unless an appeal based on hardship is made in accordance with the requirements set forth herein. If an appeal is filed in a timely manner, Medicaid HCBS will continue until a final decision is rendered. The provider is not responsible for collecting the monthly payment during the appeal period. However, if no exception is granted, HCBS terminates until the debt to the State is settled or appropriate repayment arrangements are made as indicated by the EOHHS Hearing Officer. LTSS beneficiaries receiving SSI are exempt from the repayment and penalty requirements set herein.

b. Notification of changes. The LTSS beneficiary must notify the agency of changes in any factor that served as the basis for an allowance/deduction, as set forth in this Part, within no more than ten (10) days from the date the change takes effect.

c. Medicaid-certified LTSS Provider Responsibilities - The LTSS provider - whether a health care institution or HCBS provider must:

(1) Payment. Accept the liability amount from the LTSS beneficiary.

(2) Refunds. Overpayments of beneficiary liability must be refunded to the LTSS beneficiary, such as when retroactive adjustments are made.

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 05 - Institutional Long-Term Care

Medicaid Long-Term Services and Supports: Institutionally Based LTSS (210-RICR-50-05-1)

1.1 Overview and Purpose

A. Medicaid covers certain inpatient, comprehensive services, subacute and long-term services and supports as institutional benefits. The word "institutional" with respect to federal Medicaid requirements applies to benefits authorized under Title XIX of the federal Social Security Act. For the purposes of LTSS, Medicaid recognizes three distinct health institutions all of which must be licensed under State law - nursing facilities (NF), intermediate care facilities for persons with intellectual or developmental disabilities (ICF/I-DD), and long-term care hospitals (LTH), including psychiatric care facilities for children and youth under age twenty-one (21), and the Eleanor Slater Hospital. In Rhode Island, these institutions are licensed by the Department of Health as “health care facilities” under R.I. Gen. Laws Chapter 23-17.

B. The characteristics of health institutions for Medicaid LTSS coverage purposes are as follows:

1. They operate as residential facilities and assume total care of a person who is admitted.

2. The comprehensive care provided includes room and board. Medicaid LTSS provided in a home or community-based setting is specifically prohibited under Title XIX from covering room and board.

3. The comprehensive services health institutions provide are billed and reimbursed as a single bundled payment. The State may vary the services included as part of the bundled rate across institutions. Therefore, a covered service included as part of a bundled rate in one institutional setting may be billed as a separate service in another setting.

4. Medicaid payment is only available if the State licensed or certified health institution meets applicable federal standards to qualify for federal financial participation under the Medicaid State Plan.

5. Health institutions are subject to regulatory oversight, including surveys at regular intervals, to maintain their certification, license to operate, and status as Medicaid providers; and

6. The rights and safety of patients and residents are protected in accordance with Title XIX of the Social Security Act at 42 U.S.C. §§1902(i), 1902(y) and 1919(h) and R.I. Gen. Laws Chapter 23-17-19.1.

1.2 Legal Authority

A. This Part is promulgated pursuant to the following federal and state authorities:

1. Federal Law -- Title XIX of the U.S. Social Security Act 42 U.S.C. §§ 1396a, 1902(a), 1905, 1913, 1915(c)-(k), 1917(f),1919, 1922.

2. Federal Regulations -- 42 C.F.R. §§ 431.151,433.15, 433.36(h), 435.1110, 440.160, 441.154, 447.15 and 20-21,447.257, 447.204, 456.600-665, 483.440, and 488.430-442.

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

B State Authority R.I. Gen. Laws Chapters 23-17; 40-8; and 42-35-3(c).

1.3 Definitions

A. For the purposes of this Part, the terms below are defined as follows:

1. “Institute for Mental Disease” or “IMD” means any hospital, nursing facility, or other licensed health facility or institution of more than sixteen (16) beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

2. “IMD exclusion” means the provision in Section 1905(a)(B) of Title XIX of the Social Security Act, the federal Medicaid law, that prohibits federal matching payments for psychiatric, behavioral health, or substance use treatment services provided for any person in an IMD who is under sixty-five (65) years of age except for inpatient psychiatric hospital services for children and youth under age twenty-one (21).

3. “Preadmission Screening and Resident Review” or “PASRR” means the evaluation for serious mental illness and/or intellectual disability that is conducted by a NF and reviewed by the State for all persons seeking admission to a NF as set forth in Subchapter 00 Part 5 of this Chapter.

4. “Primary care essential benefits” means and includes non-LTSS Medicaid health coverage, and includes an array of acute, subacute, and specialty essential benefits, as identified under the Medicaid State Plan, provided by licensed health professionals. These essential benefits include, but are not limited to: health promotion, disease prevention, health maintenance, counseling, patient education, various specialty services and diagnosis and treatment of acute and chronic

medical and behavioral health illnesses and conditions in a variety of health care settings (such as office visits, inpatient, home care, day care).

1.4 Accessing Medicaid in Health Institutions

A. Medicaid LTSS is available to applicants and beneficiaries who meet the non-financial, financial and functional/clinical eligibility criteria for eligibility set forth in Subchapter 00 Part 5 of this Chapter.

1. Continuous need for LTSS - A person must have an established need for continuous LTSS as set forth in Subchapter 00 Part 1 of this Chapter to qualify for LTSS in a health institution.

2. Highest need for LTSS -- As indicated in the provisions on functional/clinical eligibility in Subchapter 00 Part 5 of this Chapter, access to LTSS in health institutions is tied to the level of need. Under the terms of the State's Section 1115 demonstration, an applicant or beneficiary must have the highest need for an institutional level of care to access care in a nursing facility, ICF/I-DD or long-term hospital.

B. Federal and state laws prohibit licensed health institutions from discriminating against a person solely because of health care payer. Accordingly, a health institution is not permitted to deny admission for LTSS on this basis to an otherwise qualified Medicaid beneficiary. Health institutions must adhere to the applicable notice and due process requirements specified herein prior to discharging a person based on the loss of Medicaid eligibility.

C. Medicaid LTSS in health institutions is a Medicaid State Plan covered benefit. Accordingly, Medicaid beneficiaries residing in health institutions have access to the full array of covered primary care essential benefits and long-term services and supports. The scope of Medicaid covered services each type of health institution provides differs, depending on licensure status and the needs of the populations they serve. The State must assure a beneficiary has access to a needed covered service in situations in which the health institution where he or she resides does not have the capacity or authority to provide that service.

1.5 Medicaid LTSS in Nursing Facilities

A. In general, licensed nursing facilities provide a mix of the following services:

1. Skilled nursing -- Intermittent or continuous skilled nursing or medical care and related services to address a clinical condition and/or functional limitation;

2. Subacute care -- Rehabilitative services needed due to injury, disability, or illness;

3. Long term services and supports -- Health-related services and supports (above the level of room and board) needed regularly due to a clinical or functional disability. Previously referred to as “custodial care”;

4. Hospice care - An array of services furnished to terminally ill beneficiaries including, nursing, medical social services, physician services, counseling services for the beneficiary, family members, and/or other care givers. When provided in a NF, hospice is an elective service in which the beneficiary waives access to treatments to cure the terminal illness in favor of palliative care. This election may be revoked at any time.

B. There is no exhaustive list of required Medicaid services in the NF benefit. A Medicaid participating NF is required to provide, or arrange for, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as established in a beneficiary’s individualized plan of care.

C. In accordance with the Rhode Island Medicaid State Plan and federal regulations:

1. Minimum services -- A NF must provide, and residents may not be charged for, at least:

a. Nursing and related services;

b. Specialized rehabilitative services including any required for residents who have a mental illness or intellectual disability, that are not provided or arranged for by the State, as specified in the PASSR evaluation set forth in Subchapter 00 Part 5 of this Chapter;

c. Medically related social services;

d. Pharmaceutical services including acquiring, receiving, dispensing, and administering of drugs and biologicals;

e. Dietary services individualized to the needs of each resident;

f. Professionally directed program of activities to meet the interests and needs for well-being of each resident;

g. Emergency dental services and routine dental services covered under the State Plan;

h. Room and bed maintenance services; and

i. Routine personal hygiene items and services.

2. The NF is not required to but may provide and charge residents for:

a. Private rooms, unless medically needed;

b. Specially prepared food, beyond that generally prepared by the facility;

c. Access to and use of social and electronic media, including the internet, and/or a telephone, television, or radio;

d. Personal comfort items including tobacco products and confections;

e. Cosmetic and grooming items and services in excess of those included in the basic service;

f. Personal clothing, reading materials, gifts, and/or room accoutrement including flowers, plants, hanging pictures or decorations;

g. Social events and activities beyond the facility's established program; and/or

i. Special care services not included in the facility's Medicaid payment rate.

3. Payer of last resort -- Medicaid is the payer of last resort for all NF services.

a. Full dual eligible Medicare and Medicaid eligible beneficiaries. Medicaid payment for NF services provided to Medicaid-Medicare dually eligible beneficiaries is only available if Medicare payment is not available. The State pays the Medicare premiums and co-insurance and deductibles for dual eligible beneficiaries with income up to 100 percent of the federal poverty level (FPL) or who are medically needy eligible for LTSS and do not include such Medicare costs toward their monthly spenddown.

b. Partial dual eligible beneficiaries. Medicare beneficiaries who do not qualify for Medicaid LTSS due to excess resources, may apply for Medicaid coverage to cover Medicare co-insurance for skilled services through the State's Medicare Premium Payment Program.

4. Payment authorization - Payment for NF services is based on a per diem rate. Accordingly:

a. First day. Payment for NF services by the State begins on the first day of eligibility or the date in which the beneficiary is admitted and receiving services, whichever comes later and without regard to the hour of admission.

b. Last day. Payment does not cover NF services on the last day beneficiaries are in a NF, regardless of the hour of discharge from the facility.

c. Bed-hold days. The State does not pay for NF services to retain a bed or placement. When a beneficiary leaves a NF for a hospital stay or any other temporary absence, the State ceases making payment to the facility beginning the day after the beneficiary leaves the NF. NF personnel must notify the State of the beneficiary's departure as soon as possible, but no later than ten (10) business days.

d. PASSR. No authorization for NF payment is made until the PASSR evaluation has been completed.

1.5.1 Accessing NF Coverage

A. The State maintains a "No Wrong Door" policy for anyone seeking LTSS. Therefore, an applicant seeking initial Medicaid LTSS eligibility is treated the same irrespective of whether he or she is living at home or in a community-based supportive living arrangement, residing in a NF, or a patient in a hospital or other health institution. Once a determination of LTSS eligibility is completed, services in a NF are authorized providing all other factors affecting access have been met.

B. Certain factors affect access to Medicaid LTSS in a NF, including:

1. Age -- LTSS in a NF is available to eligible beneficiaries who are age twenty-one (21) and older. Medicaid treats LTSS for children and youth under age twenty-one (21) as a separate benefit. There is no difference in the range of NF services Medicaid covers for children and youth who have the applicable level of need.

2. Continuous need for LTSS - To qualify for Medicaid LTSS, an applicant must have an established need continuous long-term care as defined in Subchapter 00 Part 1 of this Chapter;

3. Highest level of need - Medicaid coverage of LTSS in a NF is available only to applicants and beneficiaries who have been determined in the functional/clinical eligibility process to have the highest need for the NF level of care. There are exceptions. Both the functional/clinical eligibility criteria and the exceptions are set forth in Subchapter 00 Part 5 of this Chapter.

4. PASSR - All persons seeking admission to a NF are subject to a PASSR evaluation and, as appropriate, the development of a treatment plan in accordance with Subchapter 00 Part 5 of this Chapter.

C. There are no waiting lists for Medicaid NF services. In accordance with R.I. Gen. Laws Chapter 40-8.10, a beneficiary determined to have the highest NF level of need who is receiving LTSS in a home or community-based (HCBS) setting may request a transfer to a NF if a waiting list for services develops, placement in the HCBS setting fails, or a hospital stay occurs without a re-evaluation of functional/clinical level of need if otherwise still eligible.

1.6 Medicaid in an ICF/I-DD

A. Intermediate care facility services for people with intellectual/developmental disabilities (ICF/I-DD) is an optional Medicaid benefit that provides comprehensive and individualized health care and rehabilitation services to optimize the functional status and independence of beneficiaries. In Rhode Island, ICF/I-DDs are licensed health care facilities that serve a limited number of beneficiaries in need of, and receiving, active treatment (AT) services.

B. The ICF/I-DD service is the most comprehensive benefit in Medicaid LTSS. In general, ICF/I-DD Medicaid covered services include, but are not limited to:

1. Active treatment - In an ICF/I-DD, AT is a continuous, aggressive, and consistent implementation of a program of specialized and generic training, treatment, and health or related services, directed toward helping a beneficiary function with as much self-determination and independence as possible. All services including health care services and nutrition are part of the AT, which is based on an evaluation and individualized program plan (IPP) by an interdisciplinary team. AT provides a continuous program of habilitation that excludes services to maintain generally independent beneficiaries who are able to function with little supervision.

2. Day programs -- ICF/I-DD residents work in the community, with supports, or participate in vocational or other activities outside of the residence and engage in community interests of their choice. These activities are collectively often referred to as “day programs” and are often included as AT, though they may be covered separately as an HCBS core service for a beneficiary transitioning from an ICF/I-DD to a community setting.

C. An applicant must meet the requirements for services set forth in R.I. Gen. Laws Chapter 40.1-21 including a continuous need for LTSS and need active treatment for an intellectual or developmental disability that was manifested prior to age twenty-two (22). The applicant must also meet the functional/clinical eligibility criteria for the highest need for the level of care typically provided in an ICF/I-DD as indicated in Subchapter 00 Part 5 of this Chapter.

D. Under the State’s Section 1115 demonstration, the Medicaid ICF/I-DD level of care is generally provided in the least restrictive setting that is appropriate to meet a beneficiary’s needs. Accordingly, Medicaid covers AT both at home and in an array of community-based settings that offer beneficiaries greater independence than services in an ICF/I-DD health institution typically allow. Medicaid LTSS in an ICF/I-DD is thus reserved for only those beneficiaries who are unable to safely obtain the full range of services they need in an HCBS setting or a health institution that provides the same or a more extensive set of AT as well as the Medicaid covered services necessary to address other chronic health conditions.

1.7 Medicaid LTSS in a Hospital

A. Medicaid LTSS in a hospital is a Medicaid State Plan covered service for certain applicants and beneficiaries who meet age and need requirements. Access is limited by the provision in federal law which defines any health institution which provides behavioral health, psychiatric, substance use or related services to more than sixteen (16) beds as an "Institute for Mental Disease." Federal Medicaid matching funds are not available for LTSS provided in an IMD for beneficiaries aged 21 through 64. In addition, the State does not currently license any health institutions as "long-term acute care treatment (LTAC) facilities." This is the category of licensure for hospitals that provide an array of LTSS for people with non-IMD chronic and disabling conditions. Within these limitations, Medicaid LTSS hospital services are available only as follows:

1. Habilitation - Persons who have highest level of need for habilitative services may access the care they need in a hospital setting if HCBS options are unavailable.

2. Psychiatric Services Under Age 21 -- Medicaid covered hospital services are covered for children and youth through age twenty-one (21) in psychiatric residential treatment facilities (PRTFs). A PRTF provides intensive, short term comprehensive mental and behavioral health services for a range of clinical conditions that can most effectively be addressed in a residential treatment facility in collaboration with family members, other agencies, and the community to offer strengths-based, culturally competent, medically appropriate treatment for mental illness and emotional and behavioral issues.

3. Over age 65 - Medicaid LTSS covers IMD services in a hospital or NF for persons sixty-five (65) and older. To access these services, an applicant or beneficiary must be found in the PASSR evaluation process to require services for a mental illness or intellectual disability in accordance with Subchapter 00 Part 5 of this Chapter. Medicaid covered services are based on need and include the full range of State Plan and waiver services required by the PASSR care plan.

B. Medicaid covers the full period of LTSS in a hospital beginning on the date of eligibility. Payment is not made for the date of discharge, irrespective of the time at which it occurs.

1.8 Medicaid LTSS Beneficiaries Receiving SSI

A. SSI recipients who are receiving Medicaid LTSS in a health institution may continue to receive full SSI benefits for up to three (3) months if they have an intent to return to the community within ninety (90) days. A treating, licensed health care practitioner must certify to both the State and the federal Social Security Administration (SSA) that the period of LTSS in the health institution is not expected to exceed ninety (90) days and that continuation of the SSI benefit is necessary for the beneficiary with SSI to retain his or her home. If the beneficiary remains in the health institution for a longer period than expected, the SSA terminates or reduces the SSI payment as appropriate.

B. SSI payments for adults with disabilities who are working and qualify for Section 1619(b) of Title XX, may receive up to two (2) months of continuing SSI benefits when admitted to a health institution if there is an expectation that the beneficiary will continue to work or resume working within the sixty (60) day period.

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 05 - Institutional Long-Term Care

Uniform Accountability Procedures for Title XIX Resident Personal Needs Funds in Community Nursing Facilities, ICF/DD Facilities, and Assisted Living Residences (210-RICR-50-05-2)

2.1 Introduction and Overview

Use of and accountability for funds of residents residing in community medical care, ICF/DD facilities and nursing facilities is an essential requirement for the protection of the residents' rights. In order to ensure proper program and fiscal accountability for these funds and to meet federal law and regulations, the following procedures must be in effect in all nursing facilities for whom EOHHS is responsible for payment through the Title XIX Medicaid Program.

2.2 Legal Basis

These rules are promulgated pursuant to the authority set forth in R.I. Gen. Laws Chapter 40-8 (Medical Assistance) and various sections in the R.I. Gen. Laws including §§ 40-8-32 and 23-17.5-15 related to rights of nursing facility residents; C.F.R. 42 § 483.10; and Title XIX of the Social Security Act. Additional authority is derived from the State's Medicaid State Plan and the Rhode Island Comprehensive Section 1115 Demonstration, as approved in final form on February 25, 2014, and as subsequently amended.

2.3 Definitions

A. "Applied income" means the amount of income a Medicaid beneficiary is required to contribute to the cost of his or her care.

B. "Assisted living residence" or "ALR" means a publicly or privately operated residence that provides directly or indirectly by means of contracts or arrangements personal assistance and may include the delivery of limited health services, as defined under R.I. Gen. Laws § 23-17.4-2(12), to meet the resident's changing needs and preferences, lodging, and meals to six (6) or more adults who are unrelated to the licensee or administrator, excluding however, any privately operated establishment or facility licensed pursuant to R.I. Gen. Laws 23-17 and those facilities licensed by or under the jurisdiction of the Department of Behavioral Healthcare, Development Disabilities and Hospitals, the Department of Children, Youth, and Families, or any other state agency.

C. "Cost of care" means the costs of providing care to a resident of a nursing facility, including nursing care, personal care, meals, transportation and any other costs, charges, and expenses incurred by a nursing facility in providing care to a resident. Costs of care

shall not exceed the customary rate the nursing facility charges to a resident who pays for his or her care directly rather than through a governmental or other third-party payor.

D. “Executive Office of Health and Human Services" or "EOHHS” means the state agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 within the executive branch of state government and serves as the principal agency for the purposes of managing the Departments of Children, Youth, and Families (DCYF); Health (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The EOHHS is designated as the “single state agency,” authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

E. “Intermediate Care Facility for Persons with Intellectual/Developmental Disabilities" or "ICF/IDD” means a State-licensed health care facility that provides long-term care and services to persons with intellectual /developmental disabilities.

F. "Nursing facility" means a nursing facility licensed under R.I. Gen. Laws Chapter 23-17, which is a participating provider in the Rhode Island Medicaid Program.

2.4 Personal Needs Funds - Requirements

A. The Department of Health, will review, certify and re-certify that the facility has adopted the written policies and procedures included herein pertaining to the resident accounts, and verify that such policies and procedures are being followed.

B. The EOHHS will interview residents and review resident records to determine whether they:

1. Have access to their personal funds held by the facility.

2. Know the current status of their accounts.

3. Receive in writing, and have explained if necessary, at least quarterly accountings of transactions made on their behalf.

4. Can ensure that their resources, including personal needs funds, are within the limits for continued eligibility.

5. Review resident’s records to verify a quarterly accounting of deposits, withdrawals and balances has been completed.

C. In cases in which a member of the resident’s family or a guardian assumes responsibility for personal needs funds due to an inability of the resident to manage such funds, the above points will be addressed to such persons rather than the resident, as appropriate.

D. EOHHS, or its designee, will audit residents' personal needs accounts held by the facility to ensure accountability within the procedures and requirements specified herein.

E. Resident personal needs allowances are for the sole use of the resident for such items that include, but are not limited to, haircuts, beauty parlor, tobacco, clothing, cellular telephone service and preference brand items. Personal needs allowances may be used for the payment of reserve bed days but may not be used for the payment of applied income balances or items covered as routine services. Personal needs allowances may not be used for items which the facility is reimbursed through the Medicaid Program.

F. Each facility shall obtain, upon admission from the resident, guardian, next of kin or person responsible for the resident, a signed and witnessed document ("Personal Needs Fund Authorization Document") indicating the wishes of the resident as to the manner in which personal funds are to be handled. For residents who cannot sign the authorization document, the "Personal Needs Fund Authorization Document", it is required that two (2) appropriate employees sign the document and attach a statement to that effect. (A recommended copy is available for downloading on the EOHHS website http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Rules/Personalneedsauthordocumentjan2018.pdf). An authorization document must be on file for all residents who have funds in the personal needs fund, including non-Medicaid residents. The recommended copy clearly provides the following choices:

1. Resident as responsible party.

2. Guardian, next of kin, or other individual as responsible party.

3. Facility as responsible party.

4. In addition to § 2.4(E) of this Part, periodically, monies are left by the responsible party above for incidentals to be administered by the facility in accordance with these regulations. The amount on hand cannot exceed one month's personal needs allowance. If the funds exceed this amount, a new authorization document must be established for the resident.

G. If the signed statement indicates the resident's choice is for the facility to handle the personal needs funds, the following requirements must be met:

1. The responsibility for handling the resident personal needs funds should be limited to specific individuals who are accountable for such funds. Each facility must maintain a surety bond for the personal needs funds in accordance with C.F.R. 42 § 483.10(f)(10)(vi). The obligee of the surety bond must be the State of Rhode Island. The amount of the surety bond must be greater than all personal funds of the residents at the facility.

2. Each resident must be given a written accounting of his/her deposits withdrawals and balances at least quarterly. The facility must keep a copy of such itemized accounting with the resident's records.

3. Resident personal needs funds must not be commingled with general funds of the facility or with any other funds.

4. When the individuals balance exceeds $50.00, the excess shall be deposited into an interest-bearing checking account in the name of the facility followed by the words “Resident Personal Needs Funds”, an interest-bearing savings account in the name of the facility followed by the words “Resident Personal Needs” or into a savings account in the name of the resident and his/her designee. The resident savings accounts must remain in the custody of the facility. Interest earned in the checking or savings account must be pro-rated to each resident having a balance in the account.

5. Individual resident ledger cards showing name, deposit, withdrawals and balance for checking, savings and petty cash accounts must be established and maintained by the facility. It is noted that if a facility utilizes and maintains an Imprest petty cash fund, petty cash does not have to be listed on the ledger card.

6. A separate petty cash fund entitled “Petty Cash - Residents Personal Needs” showing original balance, withdrawals supported by signed receipts, deposits in the petty cash fund from the checking account entitled “Resident Personal Needs”, and balance on hand. Resident personal needs funds petty cash must not be co-mingled with the operating accounts petty cash fund, or any other petty cash funds and the operating accounts petty cash fund must not be utilized for resident personal needs funds.

7. The amount of petty cash - resident personal needs account must not exceed the amount of $50.00 (or any subsequent increase to the personal needs allowance) for each resident choosing the facility to handle their funds.

8. Each withdrawal from the resident personal needs accounts (petty cash, checking or savings) shall be documented by a two-part signed and witnessed receipt showing date in full, name of resident, amount of withdrawal and purpose. The original is to be kept by the facility and the copy given to the resident. For residents who cannot sign, two (2) signatures of appropriate employees would be required. For withdrawals for such items such as hairdresser, bus trips, a master list would be an acceptable receipt if signed by the vendor and the representative from the facility who pays the invoice.

9. The resident personal needs ledgers, when totaled, will agree to the balance of the “Resident Personal Needs” checking account, individual savings account if applicable, plus the amount represented in the resident personal needs - petty cash account. Residents are not allowed to carry negative balances in their accounts. This reconciliation must be done on a monthly basis and retained for verification at time of audit.

10. The nursing facility must notify the resident in writing when his/her balance reaches $200.00 less than the resource eligibility guideline, that Medicaid eligibility is jeopardized if the account exceeds the guideline.

11. If the statement indicates the resident, guardian, next-of-kin, or other person responsible for the resident is to handle the personal needs funds, the facility shall have on file a receipt signed by the resident or other responsible person to ensure that each month's personal needs check or funds were actually received by the resident or other responsible person. Such receipt must show the amount of the check or the amount of money received by the resident or other responsible person. This requirement will apply only in those instances in which checks for personal income including SSI are mailed directly to the facility. A bank processed cancelled check is acceptable as evidence of receipt.

H. Disposition of resident personal needs funds upon:

1. Discharge,

2. Transfer to another long-term care facility, or

3. Death:

a. Upon discharge to community living, the resident shall be given his/her savings passbook and the funds so accumulated to his/her ledger from the resident personal needs checking account, and shall sign a receipt for such savings passbook and balance of personal needs funds.

b. Upon transfer to another long-term care facility, the resident's savings passbook and balance of resident's personal needs funds shall be transmitted to the administrator of the new facility within ten days of such transfer. The administrator of the new facility shall furnish a signed receipt for said savings passbook and balance of personal needs fund to the administrator of facility from which said resident was transferred.

c. Upon the death of a Medicaid resident, a facility shall, within ten days, transmit a notarized statement, namely, the "Notarized Statement Related to Amount of Personal Needs Money Available Upon a Resident's Death" (See form available for downloading on the EOHHS website http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Rules/Personalneedsauthordocumentjan2018.pdf) indicating the amount of personal needs money on hand after funeral expenses. Funeral expenses are designated to be the first paid. Copies of receipts, obtained either from the funeral home or the relative responsible for the funeral should be included.

d. If the deceased recipient is survived by a spouse, a child under twenty-one, or a child that is blind or permanently disabled in accordance with Title XVIII of the Social Security Act, the balance of the personal needs

funds on hand, after payment of funeral expenses, may be transmitted to those individuals.

e. If there is a balance in the Medicaid resident's personal needs account, after payment of the above noted disbursements, a check payable to EOHHS in that amount shall be sent along with the copy of the notarized statement and receipts to EOHHS at the address listed on the form.

f. If there is a $0.00 balance, the "Notarized Statement Related to Amount of Personal Needs Money Available Upon a Resident's Death" form must be filled out and sent in. Resident personal needs funds cannot be utilized for the payment of applied income balances.

2.5 Assisted Living Residences

Assisted living residences that maintain personal needs funds for their residences shall sustain compliance with the provisions of R.I. Gen. Laws §§ 23-17.4-16 (a)(2)(xiii)(A), (B), (C), and (D) and the applicable rules promulgated under R.I. Gen. Laws Chapter 23-17.4 by the Rhode Island Department of Health.

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 10 - Home & Community Based LTSS

Medicaid Long-Term Services and Supports: Home and Community-Based Services (HCBS) (210-RICR-50-10-1)

1.1 Overview and Purpose

A. Medicaid LTSS was only available to beneficiaries in institutional settings until 1983 when Congress amended Title XIX of the Social Security Act to add Section 1915 (c) which established the authority for home and community-based service (HCBS) waivers. Rhode Island was among the first states to pursue this authority and, in that first year alone, received approval for four (4) Section 1915 (c) waivers. By the time Rhode Island sought approval for its program-wide Medicaid Section 1115 waiver demonstration, the State was administering eleven, separate Section 1915 (c) waivers, many of which had distinct eligibility requirements. The State consolidated these separate HCBS waivers in 2009 when the federal government approved Rhode Island's innovative Section 1115 demonstration waiver.

B. Under the broad authority of the State's Section 1115 waiver, Rhode Island has established a core set of home and community-based services which are available to LTSS beneficiaries in multiple living arrangements. The scope of HCBS available to a beneficiary varies somewhat depending on the type of institutional eligibility a person is seeking (i.e., nursing facility (NF), intermediate care facility for persons with intellectual or developmental disabilities (ICF/I-DD), or long-term care hospital (LTH)), level of need as measured by the applicable evaluation instrument (e.g., high or highest need for the NF services or service intensity scale for ICF/I-DD), and the person-centered planning process. The purpose of this Part is to identify the full range of Medicaid HCBS options available to LTSS beneficiaries, depending on their level of need, as determined in Part 50-00-1 of this Title.

1.2 Legal Authority

A. This Chapter is promulgated pursuant to the following federal and state authorities:

1. Federal Law -- Title XIX of the U.S. Social Security Act 42 U.S.C. §§ 1396a, 1115, 1902, 1903, 1905, 1915, 1919, 1929, and 1934 (a).

2. Federal Regulations -- 42 C.F.R. Part 441 including §§ 441.180, 441.300 to 310, 441.350 to 365 and 42 C.F.R. §§ 430.25, 435.217, 440.180, 441.700, and 460.92(b).

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

B. State Authority R.I. Gen. Laws -- §§ 40-8.9.9; 40-8.10; 40-8.13, 42-66; and 40.1-22.

1.3 Definitions

A. For the purposes of this Part, the terms below are defined as follows:

1. “HCBS living arrangement” means a private home in which a beneficiary lives, or a community-based supportive care residence as defined in R.I. Gen. Laws § 40-8.13-12 and § 1.6(A)(4) of this Part that has been certified by Medicaid and authorized by the State, by licensure or certification standards, to provide long-term care services and supports to one or more persons. This category includes assisted living residences, State and provider operated groups homes, shared living arrangements, the home of the beneficiary and other private residences.

2. “Programs of All-Inclusive Care for the Elderly” or “PACE” means the Medicaid State Plan service delivery option for beneficiaries who are dually eligible for Medicare and Medicaid. PACE is available for beneficiaries opting for HCBS who meet the NF level of care at the “high” or “highest” level.

3. “RIte@Home” means the shared living, supportive care living arrangement administered by the Executive Office of Health and Human Services (EOHHS) for persons who have LTSS needs that meet the NF level of care.

1.4 Accessing Medicaid Home and Community Based Services

A. Medicaid LTSS is available to applicants and beneficiaries who meet the non-financial, financial and functional/clinical eligibility criteria for eligibility set forth in this Chapter. Under the terms of the State's Section 1115 demonstration waiver, a person seeking Medicaid LTSS must have an established need as set forth in Subchapter 00 Part 1 of this Title but is not required to be receiving long-term care at the time an application is made. In addition, it is not necessary for an applicant to make a choice of the type of LTSS -- HCBS or health institution -- when requesting Medicaid coverage. As indicated in Part 5 of this Chapter, a person's level of need in the functional/clinical eligibility determination process affects the range of Medicaid LTSS options and settings that may be available.

B. Persons seeking Medicaid HCBS are subject to a functional assessment that includes a standard set of evaluation criteria that consider the full range of the person's physical, medical, behavioral health and social needs. This assessment takes a variety of forms and may be performed by an agency representative or a contractual entity. The assessment is a component of the person-centered planning process, when feasible, and is one of several factors reviewed when determining whether and to what extent a person has the need for an institutional level of care and the scope of HCBS authorized for payment.

C. The Medicaid State Plan and Rhode Island's Section 1115 demonstration waiver authorize the State to implement certain conditions affecting access to Medicaid HCBS including:

1. No room and board coverage -- Medicaid does not provide coverage for room and board costs when LTSS is provided in a home or a community-based setting. The post-eligibility treatment of income process, set forth in Subchapter 00 Part 8 of this of this Title, provides various allowances that protect -- that is, treat as unavailable -- a portion of beneficiary's income for room and board costs. Other forms of public assistance are also available to help pay shelter and food costs including the federal Supplemental Security Income (SSI) and Supplemental Nutrition Assistance (SNAP) programs and the State's optional Supplemental Payment (SSP) program, as well as a variety of publicly funded housing and meal support programs. Agency representatives are available to assist applicants and beneficiaries seeking these additional forms of assistance.

2. Needs-based -- The scope, amount and duration of authorized HCBS a beneficiary receives is determined by needs level, as specified in Subchapter 00 Part 5 of this Title, and within these parameters the goals and outcomes the beneficiary establishes in the person-centered planning process. Only the HCBS that have been authorized by the Medicaid State Plan and Section 1115 demonstration are covered and, therein, only the service array associated with a beneficiary's LTSS level of need -- high or highest -- may be accessed unless the exceptions established in Subchapter 00 Part 5 of this Title apply.

3. Expedited eligibility – Expedited eligibility for persons seeking Medicaid LTSS in a home and community-based setting is available in certain circumstances. The provisions governing expedited eligibility for Medicaid LTSS are located in Subchapter 00 Parts 1 and 5 of this Title.

1.5 Person-Centered Planning

A. Federal regulations require states providing HCBS through Section 1915 and Section 1115 Medicaid waiver authorities to implement a person-centered planning process (PCPP) that is driven by the Medicaid beneficiary. The PCPP serves as the basis for the authorization of the Medicaid HCBS.

B. The person-centered planning process is directed by a Medicaid LTSS applicant/beneficiary (or family members) for the purposes of identifying the strengths, capacities, preferences, needs and desired outcomes that become the core of an individualized plan of LTSS care. The applicant/beneficiary will lead the person-centered planning process where possible. The applicant's/beneficiary's representative should have a participatory role, as needed and as defined by the applicant/beneficiary, unless State law confers decision-making authority to the legal representative.

C. The LTSS applicant/beneficiary may invite others to participate in the PCPP who may enable or assist in identifying and accessing a personalized mix of paid and unpaid services and supports that will assist him or her in achieving personally defined outcomes in the most inclusive community setting. The applicant/beneficiary sets the planning goals for achieving these outcomes in collaboration with the other PCPP participants he or she has selected. The plan of care incorporates both the personally defined outcomes

of the applicant/beneficiary and the training supports, therapies, treatments, and or other services the individual is to receive to achieve those outcomes.

1.5.1 Principles of Person-Centered Planning

A. State agencies that administer programs that provide Medicaid LTSS in the home and community-based settings adhere to the principles of the PCPP to the full extent feasible pending full implementation of the process EOHHS-wide.

1. General principles -- The PCPP must be led by applicant/beneficiary and include participants chosen by the applicant/beneficiary. The PCPP strives to:

a. Inform and support. Provide the information and support necessary for the applicant/beneficiary to direct the process to the maximum extent possible;

b. Avert service delays. at times and locations of convenience to the applicant/beneficiary;

c. Reflect personal values and preferences. Be conducted in a manner that respects the values and prioritizes the preferences of the applicant/beneficiary and in plain language;

d. Facilitate person-centered consensus-building. Includes strategies for solving disagreements in a manner that supports the interests and informed choices of the applicant/beneficiary;

e. Offer informed choice. Describes the full range of HCBS service options within the applicable level of care tier or classification;

f. Promote community participation and integration. Identifies how the outcomes and goals of the applicant/beneficiary are strengthened and supported by social relationships, community participation, employment, income and savings, healthcare and wellness, education and others.

g. Encourage independence. Identifies what services are self-directed.

h. Manage risks. Potential risks and strategies for mitigating them, including back-up plans and providers.

2. Person-centered plan (PCP) -- The principles of the PCPP inform the determination of functional/clinical eligibility and therefore the scope of service options available based on level of need. The PCP must be written in plain language and in a manner that is understandable to persons with disabilities or limited English proficiency and incorporates the goals and desired outcomes of the beneficiary within this context and the agreed upon roadmap for achieving them including, but not limited to: choice of setting; clinical and support needs; caregivers and service providers, both paid and unpaid and their respective roles

and responsibilities for meeting those needs; self-directed care, if any; and integrated employment opportunities and requirements. The applicant/beneficiary must indicate agreement with the plan and shares the plan of care, as appropriate, with other participants in the PCPP process and responsible providers.

B. The PCPP is ongoing and continues after Medicaid HCBS is initially authorized and Medicaid payment begins. The State is required to support the continued engagement of a Medicaid beneficiary and/or his or her family during the period in which services are authorized and, in particular, when conducting reassessments and/or redeterminations of LTSS functional/clinical eligibility that may precipitate or necessitate changes in a plan of care and/or the available service options.

1.6 Medicaid Home and Community-based Long-term Services and Supports

A. The HCBS options a LTSS beneficiary is authorized to receive depends on the determination of needs level and the person-centered care planning process (PCPP) involving the beneficiary, provider and family members or authorized representatives. The following are the Medicaid HCBS authorized under the Medicaid State Plan and Section 1115 demonstration waiver available based on need to beneficiaries:

1. Adult Companion Services -- Non-medical care, supervision, and socialization, provided to a functionally impaired adult. Companions may assist or supervise the beneficiary with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the beneficiary. This service is provided in accordance with a therapeutic goal in the service plan.

2. Assisted Living Services -- Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to HCBS beneficiaries who reside in a setting that meets the HCBS setting requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Medicaid covered assisted living services also include social and recreational programming, and medication assistance. In addition, the assisted living residence must be Medicaid certified provider and, as such, adhere to the following:

a. Medicaid covered services that are provided by third parties must be coordinated with the assisted living provider.

b. Services must be furnished in a manner that meets a beneficiary's LTSS needs in a manner that promotes self-reliance, dignity and independence. The beneficiary has a right to privacy and has the freedom to move about unless a health practitioner has certified in writing that the beneficiary has

a cognitive impairment or similar condition as to be a danger to self or others if given the opportunity to lock the door.

c. Assisted living residences with the appropriate State licensure and Medicaid certification may provide an enhanced or specialized package of services, such as dementia care, when necessary to meet a beneficiary's acuity needs. Prior authorization by the State or a Medicaid managed care plan is required.

d. Personalized services must be provided to a beneficiary residing is a single or double living unit, when both occupants consent to the arrangement, that contains sleeping and toilet facilities. Each living unit is separate and distinct from each other unit. The residence must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living room or dining room).

e. The beneficiary must retain the right to assume risk, tempered only by his or her ability to assume responsibility for that risk.

3. Case Management -- Medicaid coverage is available for case management services that assist beneficiaries in gaining access to needed HCBS and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for those services.

4. Community-Based Supported Living Arrangements (CSLA) -- Enhanced and specialized HCBS for persons with more intensive LTSS needs provided through Medicaid certified community-based providers – including certain assisted living residences, group homes for persons with developmental or behavioral health disabilities, and other adult supportive care homes. These providers are authorized by the State to address high level functional/clinical needs that otherwise would require care in an institutional- setting. To participate in the program, HCBS providers must meet standards set by the State related to minimum licensure and certification and establish and maintain an acuity-based, tiered service and payment system that ties reimbursements to: beneficiary's clinical/functional level of need; the scope of HCBS authorized and provided; and specific quality and outcome measures. Occupancy limits on the number of residents allowed in such arrangements may apply in accordance with State licensure and/or certification requirements.

5. Community Transition Services - Community transitions services are non-recurring set-up expenses for applicants and beneficiaries who are transitioning from an institutional or another provider-operated setting to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board.

a. Allowable expenses include, but are not limited to: security deposits that are required to obtain a lease on an apartment or home; essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; services necessary for the person's health and safety such as pest eradication and one-time cleaning prior to occupancy; moving expenses; necessary home accessibility adaptations; and activities to assess need, arrange for and procure needed resources; storage fees; weather appropriate clothing; assistance with obtaining needed documentations for housing agreements.

b. Allowable expenses for community transitions are only covered to the extent that they are reasonable and necessary as determined through the PCPP, are clearly identified in the person-centered service plan, and the person is unable to afford paying for the transition services, or the services cannot be obtained from other sources.

6. Day treatment and supports -- Services that are necessary for the diagnosis or treatment of a beneficiary's behavior health condition, mental illness, or disability. The purpose of this service is to maintain the beneficiary's condition and functional level and to prevent relapse or hospitalization. Range of services available includes the following:

a. Individual and group therapy with physicians or psychologists (or other health professionals to the extent authorized under State law);

b. Occupational therapy, requiring the skills of a qualified occupational therapist;

c. The services of trained psychiatric nurses, social workers, and other professionals and paraprofessionals trained to work with individuals with psychiatric illness;

d. Drugs and biologicals furnished for therapeutic purposes, that are otherwise not covered by Medicaid or Medicare;

e. Individual activity therapies that are not primarily recreational or diversionary;

f. Family counseling (the primary purpose of which is treatment of the beneficiary's condition);

g. Training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment); and

h. Diagnostic services.

7. Habilitation services – Services designed to assist beneficiaries in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in a home or community-based setting. May be included as part of integrated day services or residential habilitation services, as indicated below:

a. Day habilitation. Regularly scheduled habilitative services and related activities in a setting apart from the beneficiary's private residence. These day services focus on enabling a beneficiary to attain or maintain his or her maximum potential and are coordinated with any needed therapies in the PCP, such as physical, occupational or speech therapy.

b. Residential habilitation. Individually tailored habilitation services and supports targeted at improving skills related to living in the community. Includes adaptive skill development, assistance with the activities of daily living, community inclusion, transportation, adult education, employment supports, and the development of social and leisure skills that assist the beneficiary in living in the most integrated setting appropriate. In addition, the service covers personal care and protective oversight and supervision.

8. Homemaker services – The performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the beneficiary or caretaker regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

9. Home delivered meals -- The delivery of hot meals and shelf staples to the beneficiary's residence. These services are available to a beneficiary who has a functional dependency/disability that limits the ability to prepare meals and who requires food preparation and delivery to live in the community. Home delivered meals must provide a minimum of one-third of the current recommended dietary allowance and generally do not meet the full daily nutritional requirement.

10. Individual directed goods and services – The services, equipment, or supplies not otherwise covered by Medicaid that address an identified need in the beneficiary's service plan, including improving and maintaining the beneficiary's opportunities for full membership in the community. Individual directed goods and services are purchased from the beneficiary-directed budget. To be covered, the beneficiary must not have the funds to purchase the item or service or the item or service must not be available through another source and the item or service must:

a. Decrease the need for other Medicaid services; AND/OR

b. Promote inclusion in the community; AND/OR

c. Increase the beneficiary's safety in the home environment; AND,

d. Not be an experimental or prohibited treatment.

11. Integrated supported employment -- Integrated employment supports are services and training activities provided in regular business and industry settings for beneficiaries who have disabilities. The outcome of this service is sustained paid employment and work experience leading to further career development and integrated community-based employment for which the beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

a. Supports may include any combination of the following services: vocational/job-related discovery or assessment, person- centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits management, transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the HCBS beneficiary to be successful in integrating into the job setting.

b. Supported employment must be provided in a manner that promotes integration into the workplace and interaction between beneficiaries and people without disabilities in those workplaces.

12. Medication management/administration – Pharmacologic management including review of medication use, both current and historical, if indicated; evaluation of symptoms being treated, side effects and effectiveness of current medication(s), adjustment of medications if indicated, and prescription, provided by a medical professional practicing within the scope of his or her licensure.

13. Personal care -- A range of services and supports that enables HCBS beneficiaries to accomplish tasks that they would normally do for themselves if they did not have functional and/or clinical limitations. Personal care may take the form of hands-on assistance or cuing to prompt the beneficiary to perform a task. The services may be provided on an episodic or on a continuing basis and may be provided by a home health aide, personal care attendant, or direct service worker.

14. Personal Emergency Response System (PERS) -- PERS is an electronic device that enables HCBS beneficiaries to secure help in an emergency. The system is connected to the beneficiary’s phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein.

15. Prevocational Services – Services intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to the ability to: communicate effectively with supervisors, co-workers and customers; follow directions; attend to tasks; solve workplace problems; engage

in appropriate work conduct and meet applicable norms related to grooming and dress; and adhere to health and safety standards.

a. Participation in prevocational services is not a required pre-requisite for HCBS individual or small group supported employment services.

b. Includes volunteer work and other non-paid work that facilitate the development of general, non-job-task-specific strengths and skills that enhance a beneficiary's employability.

c. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the beneficiary in the PCPP with the assistance of the health professionals and other participants in that process. Beneficiaries receiving prevocational services must have employment-related goals in their person-centered service plan and their general habilitation activities must be designed to support such employment goals.

16. Private duty nursing -Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within their scope of practice under State law. These services are provided to a beneficiary at home.

17. Respite care -- Services provided to beneficiaries, within parameters established by the State, who are unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the beneficiary.

18. Shared-living – A supported living arrangement in which necessary core HCBSs (e.g., personal care, homemaker, chore, companion services and medication oversight) are bundled and provided in a private residence to a beneficiary by a principal caregiver who shares the home. The scope of HCBS available in share living arrangements, and service agencies, varies depending whether a beneficiary requires a NF or ICF/I-DD level of care and the extent of his or her acuity needs. The State pays the principal caregiver through the service agency for the HCBS provided to the beneficiary and for assisting in coordinating access to other needed services. Separate payment is not made for homemaker or chore services furnished to the beneficiary as these services are integral to and inherent in the provision of the shared living arrangement.

19. Skilled nursing -- Services listed in the PCP plan that are within the scope of a nurse's area of practice under State law. HCBS skilled nursing is distinguished from private duty nursing in that it is part time or intermittent and provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse in either the beneficiary's home or Medicaid certified community living arrangement.

20. Specialized medical equipment and supplies -- Specialized medical equipment and supplies are devices, controls, or appliances, specified in the plan of care, that enable beneficiaries to: increase their ability to perform activities of daily living; perceive, control, or communicate with the environment in which they live; ensure life support; or address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items. Also includes:

a. Other durable and non-durable medical equipment and medical supplies not covered under the State Plan that are necessary to address a beneficiary's functional limitations.

b. Remote devices that enable appropriately licensed health care professionals to monitor certain aspects of a beneficiary's health at home or in other residential living arrangements.

c. Items covered under HCBS funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary.

d. All items must meet applicable standards of manufacture, design and installation.

21. Supports for consumer direction – The services and supports provided by a facilitator – referred to as the service advisement agency -- that empowers beneficiaries participating in self-directed "personal choice" service delivery options under Part 2, subchapter 10 of this Chapter to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the beneficiary through the service planning and delivery process. The facilitator counsels and assists in development of the PCP which includes both paid and unpaid services and supports designed to enable the beneficiary to live at home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the PCP are temporarily unavailable.

B. Medicaid LTSS beneficiaries receiving core HCBS are entitled to all primary care essential benefits authorized under the Medicaid State Plan including home care and home modifications. Unless self-directed, HCBS are delivered by Medicaid certified providers through PACE, a Medicaid managed care plan, or on a fee-for-service basis, in accordance with the provisions set forth in Part 40-10-1 of this Title.

1.7 Limitations on the Availability of Medicaid HCBS

A. The State may establish waiting lists for an HCBS service option, including a specific setting, when demand exceeds the availability of services and/or appropriated funds.

1. Prioritized access -- During a period in which a waiting list is in effect, access to HCBS is based on level of need. Persons determined to have the highest needs

levels, including those with imminent health and safety risks, are therefore given priority access over those with lower needs levels.

2. Limits -- The State may not extend waiting lists for HCBS determined to be medically necessary by a treating health care practitioner to prevent an imminent risk to a beneficiary's health or safety.

3. Notice – Prior to the establishment of HCBS waiting lists, the State provides a full implementation plan indicating the date the waiting list takes effect, the process for notifying beneficiaries of their status and the procedures in place to ensure compliance with applicable federal and state laws and address the needs of beneficiaries at risk.

1.7.1 Limitations on Nursing Facility (NF) and Long-Term Hospital (LTH) Levels of Care

A. The limitations that apply for when waiting lists or other limitations on HCBS occur for beneficiaries who need a NF or LTH level of care are set forth in State law.

1. Highest level -- Beneficiaries with the highest need have the option of seeking admission to a NF or LTH while awaiting access to the full scope of home and community-based services. Accordingly, applicants/beneficiaries deemed to be in the highest category for a NF level of care or meet the requirement for a LTH level of care are entitled to services and must not be placed on a waiting list for Medicaid LTSS in an institutional setting. If a community placement is not initially available, beneficiaries with the highest need may be placed on a waiting list for transition to the community while receiving services in a licensed health facility that provides the type of institutionally based LTSS that meets their needs.

a. Priority Status. In the event that a waiting list for any home and community- based service becomes necessary, the EOHHS must provide services for beneficiaries determined to be NF or LTH highest need before providing services to beneficiaries that have a high need. Beneficiaries with high need are given priority access to services over beneficiaries qualifying for LTSS preventive services.

b. Continuation of Services. Services for beneficiaries with the highest need must continue in the appropriate setting unless or until their condition improves to such an extent that they no longer meet the same clinical/functional eligibility criteria.

2. High Need – Beneficiaries with a high level of need may be subject to waiting lists for certain HCBS. However, for the NF level of care, beneficiaries with a high need are afforded priority status for any such services over beneficiaries who have a preventive level of need under R.I. Gen. Laws § 40-8.10-3. Beneficiaries who meet the functional/clinical eligibility criteria for the high level of long-term hospital (LTH) care must be provided with required services in an institutional

setting until HCBS become available. Rules pertaining to the LTSS preventive level of need are located in Part 40-05-1 of this Title.

1.7.2 Limitations ICF/I-DD Level of Care for Persons with Developmental Disabilities

A. The State must adhere to the requirements set forth in the Section 1115 demonstration waiver if waiting lists or other restrictions are established for HCBS for persons with developmental disabilities. The goal is two-fold: 1) Ensure care is available for those whose medical needs cannot otherwise be addressed; and 2) Limit the availability when any community-based alternative is available.

1. Highest need -- As placement in an ICF/I-DD is not generally available, the State must give beneficiaries with the highest needs levels in Tiers D and E, as specified in Part 50-00-5 of this Title, priority access for any home and community-based services that are restricted over beneficiaries with a high need. Placement in an alternative living arrangement that provides the same or a more robust service array, including a NF or LTH, may be provided on an interim basis for any applicant or beneficiary who has clinical or functional needs requiring medical care.

2. High need -- Beneficiaries with high needs levels in Tier C are given priority access over beneficiaries with needs levels in Tiers B and A. Accordingly, beneficiaries with needs levels in Tier A have limited access to any restricted HCBS until beneficiaries with greater needs have been served.

3. Exceptions – The State may make exceptions to the priority access standards set forth herein in accordance with the provisions in Subchapter 00 Part 5 of this Title, as appropriate, or rules, regulations and procedures promulgated specifically for that purpose by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).

1.8 HCBS Setting Requirements

A. The federal government regulations beginning at 42 C.F.R. § 441.700 establish standards and criteria that states must follow when determining whether Medicaid coverage is available for certain HCBS services and settings. This section incorporates the federal standards and establishes the core HCBS for long-term services and supports. The federal standards and requirements for HCBS are designed to: provide states with more flexibility when using federal funds to pay for Medicaid in non-institutional-settings; and establish a set of standards for HCBS that ensures Medicaid LTSS beneficiaries will have full access to advantages of community life and health services in integrated settings. The EOHHS is committed to implementing a federally approved, stakeholder-driven transition plan that assures the State is in compliance with these requirements by the deadline for adoption in 2022. These regulations hereby adopt and incorporate 42 C.F.R. § 441.700 et seq. (2014) by reference, not including any further

editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

B. HCBS setting requirements include the following characteristics:

1. The setting is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as applicants/beneficiaries not receiving Medicaid HCBS.

2. The setting is selected by the applicant/beneficiary from among setting options, including nondisability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the applicant's/beneficiary's needs, preferences, and, for residential settings, resources available for room and board.

3. Ensures an applicant's/beneficiary's rights of privacy, dignity and respect, and freedom from coercion and restraint.

4. Optimizes, but does not regiment, applicant/beneficiary initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

5. Facilitates applicant/beneficiary choice regarding services and supports, and who provides them.

6. In a provider-owned or controlled residential setting, in addition to the above qualities at paragraphs (a)(l)(i) through (v) of this section, the following additional conditions must be met:

a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the applicant/beneficiary receiving services, and the applicant/beneficiary has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;

b. Each applicant/beneficiary has privacy in their sleeping or living unit:

(1) Units have entrance doors lockable by the applicant/beneficiary, with only appropriate staff having keys to doors;

(2) Applicants/beneficiaries sharing units have a choice of roommates in that setting; and

(3) Applicants/beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

c. Applicants/beneficiaries have the freedom and support to control their own schedules and activities, and have access to food at any time;

d. Applicants/beneficiaries are able to have visitors of their choosing at any time;

e. The setting is physically accessible to the applicant/beneficiary; and

f. Any modification of the additional conditions, under paragraphs (a)(l)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the applicant/beneficiary.

(8) Include an assurance that interventions and supports will cause no harm to the applicant/beneficiary.

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 10 - Home & Community Based LTSS

The Personal Choice Program (210-RICR-50-10-2)

2.1 Overview

A. The Personal Choice Program (PCP) provides consumer-directed home and community-based services to Medicaid long-term services and supports (LTSS) eligible beneficiaries. Personal Choice is a long-term care service for individuals with disabilities who are over the age of eighteen (18) or elders aged sixty-five (65) or over who meet either a high or highest level of care. Services are geared toward reducing unnecessary institutionalization by providing specialized home and community-bases services to qualified Medicaid beneficiaries at an aggregate cost which is less than or equal to the cost of institutional or nursing facility care.

B. Personal Choice is available to individuals who want to either return home or remain at home; for individuals who want to purchase their own care and services from a budget based on their individual functional needs; and for individuals who have the ability to self-direct care or who have a representative who is able to direct care for the participant.

C. The goal of the Personal Choice Program is to provide a home and community-based program providing beneficiaries with the opportunity to exercise choice and control, such as hiring, firing, supervising, and managing individuals who provide their personal care, and to exercise choice and control over a specified amount of funds in a beneficiary directed budget. Participants in the PCP are assigned to a Service Advisement Agency and Fiscal Agent to assist in making informed decisions that are consistent with their needs and reflect their unique individual circumstances.

D. The following services supplement the existing scope of services covered by Medical Assistance, Medicare, and other programs and services available to beneficiaries in the PCP:

1. Service Advisement

2. Fiscal Intermediary Services

3. Personal Care Assistance

4. PCP Directed Goods and Services

5. Home Modifications

6. Home Delivered Meals

7. Personal Emergency Response Systems (PERS)

8. Special Medical Equipment (Minor Assistive Devices).

E. PCP applicants must have the ability to manage their own personal care or if they are unable, must be willing to have a representative assist them in managing some or all of the program requirements. A representative is a person designated by the beneficiary to assist him/her in managing some or all facets of participation in the program. Beneficiaries cannot pay representatives from the PCP budget. PCP participants or their representatives hire personal care attendants (PCA) to provide personal care, and assistance with housekeeping, homemaking, and household chores.

F. All Personal Care Attendants and beneficiary representatives that have direct contact with PCP beneficiaries must submit to a National and a RI Bureau of Criminal Identification (BCI) screening and an Abuse Registry Record Check annually to be authorized to provide PCP assistance to PCP beneficiaries under the PCP. To participate in the PCP as the beneficiary's representative or in a provider (PCA) capacity, there must be no evidence of criminal activity in the BCI record check. This condition also applies to the members of a provider's household if the PCP beneficiary resides or receives services in the provider's home. Evidence of criminal activity is defined as a conviction or plea of nolo contendere in any criminal matter or the fact that the individual has outstanding or pending charges, related to any types of Disqualifying Criminal Convictions as cited in both the Personal Choice Participant/Representative Manual and Provider Manual available through the EOHHS or obtained on its website: www.eohhs.ri.gov.

2.2 Legal Authority

Title XIX of the Social Security Act provides the legal authority for the Rhode Island Medicaid Program. The Medicaid Program also operates under a waiver granted by the Secretary of Health and Human Services pursuant to Section 1115 of the Social Security Act. Additionally, R.I. Gen. Laws Chapters 40-6, 40-8, and 40-18 ("Long Term Home Health Care - Alternative to Placement in a Skilled Nursing or Intermediate Care Facility") serve as the enabling statutes for the Personal Choice Program.

2.3 Definitions

A. The following terms, which are listed alphabetically, are used in determining eligibility for the Personal Choice Program.

1. "Activities of daily living skills" or "ADLs" means everyday routines generally involving functional mobility and personal care, such as bathing, dressing, eating, toileting, mobility and transfer.

2. “Applicant” means new applicants for Medicaid as well as current recipients at any point in which eligibility is determined or redetermined.

3. “Case management services” means the coordination of a plan of care and services provided at home to persons with disabilities who are medically eligible for placement in a skilled nursing facility or an intermediate care facility. Such programs shall be provided in the person’s home or in the home of a responsible relative or other responsible adult, but not provided in a skilled nursing facility and/or an intermediate care facility.

4. “Critical incident” means any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a participant.

5. “Environmental modifications” or “Home accessibility adaptations” means those physical adaptations to the private residence of the participant or the participant’s family, required by the participant’s service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation, such as to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheel chair. All services shall be provided in accordance with applicable State or local building codes and are prior approved on an individual basis by EOHHS/Medicaid.

6. “Fiscal intermediary services” or “FI” means services that are designed to assist the participant in allocating funds as outlined in the Individual Service and Spending Plan and to facilitate employment of personal assistance staff by the participant.

7. “Home modifications” means equipment and/or adaptations to an individual’s residence to enable the individual to remain in his/her home or place of residence, and ensure safety, security, and accessibility.

8. “Home delivered meals” means the delivery of hot meals and shelf staples to the participant’s residence. Meals are available to individuals unable to care for their nutritional needs because of a functional dependency/ disability and who require this assistance to live in the community. Meals provided under this service will not constitute a full daily nutritional requirement. Meals must provide a minimum of one third of the current recommended dietary allowance. Provision of home delivered meals will result in less assistance being authorized for meal preparation for individual participants, if applicable.

9. “Instrumental activities of daily living” or “IADL” means the activities often performed by a person who is living independently in a community setting during the course of a normal day, such as managing money, shopping, telephone use, travel in community, housekeeping, preparing meals, and taking medications correctly.

10. “Medical necessity” or “Medically necessary services” means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health-related condition including services necessary to prevent a detrimental change in either medical or mental health status.

11. “Minor environmental modifications” means minor modifications to the home that may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats and other simple devises or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care and standing poles to improve home accessibility adaptation, health or safety.

12. “Participant directed goods and services” means services, equipment or supplies not otherwise provided through this program or through the Medicaid State Plan that address an identified need and are in the approved Individual Service Plan (including improving and maintaining the individual’s opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR the item or service would increase the individual’s ability to perform ADLs or IADLs; AND/OR increase the person’s safety in the home environment; AND, alternative funding sources are not available. Individual Goods and Services are purchased from the individual’s self-directed budget through the fiscal intermediary when approved as part of the ISP. Examples include a laundry service for a person unable to launder and fold

clothes or a microwave for a person unable to use a stove due to his/her disability. This will not include any good/service that would be restrictive to the individual or strictly experimental in nature.

13. “Personal care assistance services” means the provision of direct support services provided in the home or community to individuals in performing tasks they are functionally unable to complete independently due to disability, based on the Individual Service and Spending Plan. Personal Assistance Services include but are not limited to:

a. Participant assistance with activities of daily living, such as grooming, personal hygiene, toileting, bathing, and dressing

b. Assistance with monitoring health status and physical condition

c. Assistance with preparation and eating of meals (not the cost of the meals itself)

d. Assistance with housekeeping activities (bed making, dusting, vacuuming, laundry, grocery shopping, cleaning)

e. Assistance with transferring, ambulation; use of special mobility devices assisting the participant by directly providing or arranging transportation (If providing transportation, the PCA must have a valid driver’s license and liability coverage as verified by the FI).

14. “Personal emergency response” or “PERS” means an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. This service includes coverage for installation and a monthly service fee. Providers are responsible to insure the upkeep and maintenance of the devices/systems.

15. “Service advisement team” means a team, consisting of the Service Advisor, a Nurse and a Mobility Specialist, that will focus on empowering participants to define and direct their own personal assistance needs and services.

16. “Special medical equipment” or “Minor assistive devices” means the following:

a. Devices, controls, or appliances, specified in the plan of care, which enable participants to increase their ability to perform activities of daily living;

b. Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; including such other durable and non-durable medical equipment not available under the State Plan that is necessary to address participant functional limitations.

c. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished by Medicaid and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Provision of Specialized Medical Equipment requires prior approval on an individual basis by Medicaid.

17. "Supports for consumer direction" or "Supports facilitation" means empowering participants to define and direct their own personal assistance needs and services, guides and supports, rather than directs and manages, the participant through the service planning and delivery process.

2.4 SERVICE PROVISION

2.4.1 Eligibility

A. All general eligibility rules for Medicaid LTSS contained in the Medicaid Code of Administrative Rules, "Technical Eligibility Requirements", "Characteristic Requirements", and "Cooperation Requirements" (Sections 0304, 0306, 0308) apply to the PCP. Additional eligibility requirements for the PCP are as follows:

1. Beneficiaries who are either aged (age sixty-five (65) and older) or who have a disability and are at least eighteen (18) years old and are determined to have "high" or "highest" need for level of care and;

2. Individuals who have demonstrated the ability and competence to direct their own care or have a qualified designated representative to direct care, and want to either return or remain in their home.

3. Individuals who have been determined to be Developmentally Disabled and are receiving services via the Department of Behavioral Healthcare, Developmental

Disabilities, and Hospitals (BHDDH) and are interested in the Personal Choice Program must be approved by BHDDH and EOHHS Medicaid.

B. Income

1. All income eligibility rules contained the Medicaid Code of Administrative Rules, “Income Generally”, “Treatment of Income”, “Flexible Test of Income” (Sections 0386 - 0390), and as amended from time to time, apply. If Medically Needy eligible, the applied income cannot exceed the cost of services.

C. Resources

1. All resource rules contained in the Medicaid Code of Administrative Rules, “Resources Generally”, “Evaluation of Income”, “Resource Transfers” (Sections 0380 - 0384), and as amended from time to time, apply.

D. Post Eligibility Treatment of Income

1. Single Applicant:

a. Medicaid Code of Administrative Rules, “Waiver Programs and Provisions” (Section 0396.10.20), is used for personal needs deduction for Medically Needy persons.

b. Medicaid Code of Administrative Rules, “Waiver Programs and Provisions” (Sections 0396.15.05 and 0396.10.05) are used in determining applied income.

2. Married Applicant:

a. Medicaid Code of Administrative Rules, “Post-Eligibility Treatment of Income” (Section 0392.15) is used to determine the income of a married applicant with a community spouse.

3. Eligibility Determinations

a. Medicaid determines eligibility and calculates the beneficiary’s income to be allocated to the cost of care as necessary. Neither the Supplemental Security Income (SSI) payment itself nor any of the other income of an SSI recipient or former SSI recipients who are Categorically Needy under § 1619(b) of the Social Security Act may be allocated to offset the cost of the Personal Choice Program.

b. For other beneficiaries participating in the PCP, income is reviewed for accuracy.

4. Confirming Medicaid Eligibility Status

a. The Service Advisement Agency and Fiscal Intermediary Agency must confirm the beneficiary's eligibility before PCP services are initiated and at the time of each reassessment of a beneficiary's needs.

5. Redetermination of Eligibility

a. EOHHS redetermines the Medicaid eligibility of PCP participants each year, unless a change occurs prior to the annual redetermination date. Such a change might include, but is not limited to: the inheritance of money; the transfer of an asset; or the death of a spouse, which results in a change in income.

E. Involuntary Disenrollment

1. When a Medicaid-eligible participant is involuntarily disenrolled from the Personal Choice Program, the participant is referred to Medicaid to explore other available options.

2. EOHHS notifies the participant in writing that they intend to remove the participant from the Personal Choice Program, the reason for disenrollment, and informs the participant that services will be provided through Medicaid long-term care via a home health agency.

3. The participant will be involuntarily disenrolled from the PCP if he/she loses either Medicaid financial eligibility or level of care eligibility.

4. Disenrollment is determined by the Service Advisement Agency, based on an assessment in conjunction with the policies and procedures of that Agency, and/or the receipt of information from the Fiscal Intermediary or EOHHS. Involuntary disenrollment may also occur when:

a. The participant or representative is unable to self-direct purchase and payment of LTSS.

b. A representative proves incapable of acting in the best interest of the participant, can no longer assist participant, and no replacement is available.

c. The participant or representative fails to comply with legal/financial obligations as an "employer" of domestic workers and/or is unwilling to participate in advisement training or training to remedy non-compliance.

d. The participant or representative is unable to manage the monthly spending as evidenced by: repeatedly submitting time sheets for unauthorized budgeted amount of care; underutilizing the monthly budget, which results in inadequate services; and/or continuing attempts to spend budget funds on non-allowable items and services.

e. The participant's health and well-being is not maintained through the actions and/or inaction of the participant or representative.

f. The participant or representative fails to maintain a safe working environment for personal care.

g. EOHHS receives a complaint of beneficiary self-neglect, neglect, or other abuse.

h. Either the participant or representative refuses to cooperate with minimum program oversight activities, even when staff has made efforts to accommodate the participant.

i. The participant or representative fails to pay the amount determined in the post eligibility treatment of income, as described in the EOHHS Medicaid Code of Administrative Rules, "Post-Eligibility Treatment of Income" (Section 0392.15) to the fiscal agency.

j. There is evidence that Medicaid funds were used improperly/ illegally according to local, state or federal regulations.

k. A participant or representative fails to notify both the Service Advisement agency and the Fiscal Intermediary of any change of address and/or telephone number within ten (10) days of the change.

F. Voluntary Disenrollment

1. A participant or representative may request discharge from the Personal Choice Program with a thirty (30) day written notice to the service advisement agency.

2. A participant's representative must provide both the service advisement agency and fiscal intermediary with a thirty (30) day written notice stating they are no longer able to provide representative services.

G. Disenrollment Appeal

1. The service advisement agency and the fiscal intermediary agency shall inform the participant in writing of an involuntary disenrollment with the reason and provides the participant with a Medicaid appeal procedure and request forms.

2. The PCP participant has the right to appeal utilizing the standard appeals process as described in Part 10-05-2 of this Title, "Appeals Process and Procedures for EOHHS Agencies and Programs."

2.5 Appeal Process

An opportunity for a hearing is granted to an applicant/recipient or his/her designated representative, when a person is aggrieved by an agency action resulting in suspension, reduction, discontinuance, termination of a beneficiary's service or budget, or a requested adjustment to the budget is denied in accordance with the provisions of Part 10-05-2 of this Title, "Appeals Process and Procedures for EOHHS Agencies and Programs."

2.6 ADMINISTRATION AND ORGANIZATION

2.6.1 Medicaid Agency Responsibilities

A. Minimum assessment components will be specified by EOHHS and be maintained in both the Personal Choice Participant/Representative Manual and Provider Manual available through EOHHS or obtained on its website: www.eohhs.ri.gov.

B. EOHHS, and/or its agents, reviews and determines level of care based on information provided by the service advisement agency. The applicant is clinically eligible for the Personal Choice Program if either a "high" or "highest" level of care is approved.

C. EOHHS staff are responsible for the following:

1. Approve budgets and individual service and spending plans;

2. Authorization of participant-directed goods and services;

3. Provide Personal Choice participants with notice of budget amount;

4. Monitor and conduct quarterly audits of service advisement and fiscal intermediary agencies.

D. The EOHHS reviews and approves the assessment and individual service and spending plan (ISSP) for each PCP participant before services begin.

E. Any changes made to a PCP participant's ISSP must be forwarded to EOHHS for review and approval.

F. Once the ISSP is approved, EOHHS will notify the appropriate service advisement agency who will inform the fiscal agency and participant that the ISSP will be implemented.

G. EOHHS is responsible for the review of reported critical incidents with the advisement agency to determine feasibility of continuing participation in the Personal Choice Program.

H. If Medicaid fraud is either known or suspected, EOHHS will refer the case to the appropriate authorities as outlined in the Medicaid Personal Choice Program Provider Manual (http://www.eohhs.ri.gov/).

2.6.2 Service Advisement Agency Role and Responsibilities

A. The Personal Choice Program (PCP) is considered as an option based upon the needs of an applicant. The applicant is then screened to determine his/her long-term care needs. The PCP is only open to participants who have "high" or "highest" LTC needs.

B. Written documentation of the assessment will be maintained by the service advisement agency, such as the functional, mobility and health assessments.

C. The service advisor will provide the participant/representative with a copy of the approved budget and the approved ISSP.

D. Additional duties of the service advisement agency include, but are not limited to:

1. Review and assess the PCP participant's LTSS needs annually and assist in gathering the documents needed for EOHHS annual certification process. Such assessments may be conducted earlier if a participant's circumstances change.

2. Refer prospective PCP participants who have the required level of LTSS need to Medicaid for a full determination of clinical eligibility.

3. Assist the PCP participant in developing and implementing their individual service and spending plan (ISSP).

4. Monitor the PCP participant to ensure health and safety, satisfaction, adequacy of current spending plan, and progress toward participant goals in accordance with the guidelines developed by the Medicaid agency. This monitoring shall

include regular home visits and annual assessments. Documentation of such program monitoring shall be provided to EOHHS.

5. Maintain minimum monitoring guidelines in accordance with the guidelines established by EOHHS and as outlined in the Provider agreement. These guidelines are posted on the Medicaid website, http://www.eohhs.ri.gov/.

6. Complete the critical incident reporting form as outlined in the Personal Choice Provider Manual, within twenty-four (24) hours of the reported incident.

E. If Medicaid fraud is either known or suspected, the service advisement agency will refer the case to the appropriate authorities as outlined in the Personal Choice Program Provider Manual (http://www.eohhs.ri.gov/).

2.6.3 Assessment by Service Advisement Agency

A. An assessment measuring Activities of Daily Living (ADLS) and Instrumental Activities of Daily Living (IADLS) is conducted to determine participant needs. In accordance with the service provider agreements, a budget is developed based on the amount and level of assistance required, frequency of the task, and presence of any secondary conditions that would require a need for more time to complete the task. There are six (6) levels of assistance for each activity as referenced in Attachment I.

B. In addition to medical information and self-reporting, the assessor may observe or request that the participant demonstrate his/her ability to complete a task.

C. The budget amount is determined by EOHHS and may be subject to change. The budget funds are set aside by Medicaid for the purchase of assistance to meet individual participant needs. The participant determines what services are required and the amount the participant is willing to pay for those services from their budget. Participants determine the hourly wage for PCA, which can range from minimum wage up to $15.00 per hour. It is based solely on tasks such as bathing, dressing, toileting, etc. and is determined based on the amount of assistance the individual needs to complete the task, and time allotted for each task. The budget does not allow for companionship, watching, or general supervision of a participant. Access to the budget is available to the participant by computer via the Consumer Directed Module (CDM) or upon request to the Service Advisement Agency.

D. Qualifications of the service advisement agency staff are as follows:

1. Service Advisor - Must possess either a bachelor's degree or an associate's degree in Human Services or any health-related field and possess the skills and experience gained through providing case management, independent living

counseling or other community living services to people with disabilities or elders. The Service Advisor will assess for initial eligibility for the program, and reassess on an annual basis, assist in identifying and removing barriers to improve independence, assist in developing, implementing and monitoring Personal Choice services, provide training and assistance to participant or representative, and maintain contact via telephone and face-to-face meetings.

2. Nurse - Must possess a current Rhode Island Registered Nurse (RN) or Licensed Practical Nurse (LPN) license. The nurse will evaluate the participant's medical condition annually using the Personal Choice nursing assessment, provide educational opportunities to address issues raised during the medical assessment, and assist participants in identifying and accessing available community resources in the areas of wellness and health promotion and/or maintenance.

3. Mobility Specialist - May be a licensed Physical or Occupational Therapist and/or a certified Assistive Technology Practitioner as certified by RESNA (Rehabilitation Engineering and Assistive Technology Society of North America). The mobility specialist will evaluate on an annual basis the participant's ability to function within their home and in the community and make recommendations on any home modifications or equipment recommended in the assessment. They will also provide training and education in the safe use of any equipment or modifications for both the participant and any caregivers identified.

2.6.4 Fiscal Agency Responsibilities

A. Duties of the fiscal agency include, but are not limited to:

1. Oversee budget spending by PCP Medicaid participant / representative to ensure compliance with the ISSP.

2. Act as a conduit between employer (participant /representative) and EOHHS. The participant /representative shall sign all applicable forms allowing the fiscal agency to conduct business on behalf of the Medicaid-eligible participant.

3. The fiscal agency shall not reimburse the participant /representative for any service provider who does not pass a criminal background check or abuse registry screening.

4. Assist participant/representative in obtaining Worker's Compensation coverage for their employees.

5. Perform all necessary payroll functions, including but not limited to processing payroll, payroll taxes (including quarterly and year end), W-4's, 1099's.

6. Recoup from PCA's any wages paid for hours not worked, such as wages paid when participant was hospitalized.

2.6.5 Budget Development Process and Methodology

A. Personal Choice monthly budgets are based upon an assessment of participant need for hands-on assistance or supervision with ADL's (such as bathing, toileting, dressing, grooming, transfers, mobility, skincare, and/or eating) and IADL's (such as communication, shopping, housework, meal preparation, and/or shopping).

B. The assessment of need rates the participant's level of assistance required to complete each task, and the number of times the task is performed. If there is a particular condition or characteristic in addition to the disability, the participant may require the need for more time to complete a particular task. These conditions and/or characteristics do not apply to all ADL/IADL tasks; they only apply if the condition would have a direct impact on the performance of the task. Information on the applicable conditions and/or characteristics can be located in the PCP Provider Service Manual and the Participant Guide, located on the Medicaid website, http://www.eohhs.ri.gov/.

1. Determine Monthly Budget Amount: Each Activity of Daily Living (ADL) and Instrumental Activity of Daily Living (IADL) has an amount of unit and/or functional time allowed to complete the task. The monthly figures for each ADL/IADL are added together to form a monthly budget. The Personal Choice Program is a self-directed program, as such, worker's compensation insurance and administrative costs are deducted from the PCP participant's monthly budget.

a. Unit Time - the amount of time allowed to complete the task if the participant is unable to participate and requires total assistance with the task. Activity and time allotments, in minutes, are referenced in § 2.7 of this Part, Attachment I.

b. Functional Time - the amount of time allowed to complete the task if the participant is unable to participate and requires total assistance with the task and certain conditions or characteristics are present.

(1) The functional characteristics for each ADL/IADL are listed in § 2.7 of this Part, Attachment I.

2. EOHHS will implement a budget re-assessment for any budget which is decreased by five hundred dollars ($500). This second level re-assessment will be conducted by an EOHHS nurse and social worker in the home of the beneficiary.

3. Additional information concerning participant conditions and characteristics related to certain tasks may be found in the Participant Manual and/or the Provider Manual, available upon request or on the Medicaid website (http://www.eohhs.ri.gov/).

2.6.6 Participant Directed Goods and Services

A. Participants may also set aside a specified amount of their budget each month to purchase services, equipment and supplies not otherwise provided by Medicaid that address an identified need, are in the approved ISSP, and meet the following requirements:

1. Alternative funding sources are not available; and

2. The item or service would decrease the need for other Medicaid services; and/or

3. The item or service would promote inclusion in the community; and/or

4. The item or service would increase the individual's ability to perform ADLs/IADLs; and/or

5. The item or service would increase the person's safety in the home environment.

B. Limitations:

1. Some items or services that are medical in nature may be reimbursed with a health care practitioner's order.

2. Items must be necessary to ensure the health, welfare and safety of the participant, or must enable the participant to function with greater independence in the home or community, and to avoid institutionalization.

3. Items for entertainment purposes are not covered.

4. Items cannot duplicate equipment provided under Medicaid-funded primary and acute care or through other sources of funding, such as Medicare or private insurance.

5. Items purchased whose goal is to lessen the need for assistance from a caregiver will result in a redetermination of need for caregiver assistance.

C. Additional information for the participant can be found in Attachment I or in the PCP Participant Guide, located on the Medicaid website, http://www.eohhs.ri.gov/.

2.7 ATTACHMENT I

2.7.1 Six (6) Levels of Assistance:

Independent	Participant is independent in completing the task safely
Set-Up	Participant requires brief supervision, cueing, reminder and/or set-up assistance to perform the task.
Minimum	Participant is actively involved in the activity, requires some hands-on assistance for completion, thoroughness or safety. Needs verbal or physical assistance with 25% of the task.
Moderate	Participant requires extensive hands-on assistance, but is able to assist in the process. Needs verbal or physical assistance with 50% of the task.
Extensive	Participant requires verbal or physical assistance with 75% of the task.
Total Assistance	Participant cannot participate or assist in the activity, and requires 100% assistance with the task.
Not Applicable	This task does not apply to this participant.

2.7.2 Functional Characteristics for Each ADL / IADL:

ADL/IADL	Functional Characteristics
Bowel	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Dressing	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Eating	Behavioral Issues, Fine Motor Deficit, Spasticity/Muscle Tone
Grooming	Cognitive, Limited ROM, Spasticity/Muscle Tone
Mobility	Balance Problems, Decreased Endurance, Pain, Spasticity/Muscle Tone

ADL/IADL	Functional Characteristics
Shower	Balance Problems, Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Skin Care	Open Wound
Sponge Bath	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Transfers	Balance Problem, Limited ROM, Spasticity/Muscle Tone
Tub Bath	Balance Problem, Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Urinary/Menses	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Communications	No Functional Characteristics
Housework	Participant Lives Alone
Meal Preparation	No Functional Characteristics
Shopping	No Functional Characteristics

2.7.3 Activity and Time Allotments, in minutes:

Activity	Unit Time	Functional Time
Sponge Bath	30	45
Shower	20	40
Tub Bath	40	45
Dressing	15	20
Eating	20	40
Mobility	10	10
Urinary/Menses	10	15
Transfers	5	10
Grooming	8	8

Activity	Unit Time	Functional Time
Skin Care	10	10
Bowel	30	50
Meal Preparation	25	25
House Work	12.5	25
Communications	15	15
Shopping	60	60
Medications	2	5

2.7.4 ADL Multipliers:

Level of Assistance	Sponge Bath	Shower	Tub Bath	Dressing	Eating	Mobility	Urinary Menses	Transfers	Grooming	Skin Care	Bowel
Total Assist	1	1	1	1	1	1	1	1	1	1	1
Maximum Assist	.75	.75	.75	.75	.75	1	.75	1	.75	1	.75
Moderate Assist	.5	.5	.5	.5	.5	.75	.5	.75	.5	.75	.5
Minimum Assistance	.25	.25	.25	.25	.25	.75	.25	.75	.25	.25	.25
Set-Up Assistance	.15	.15	.15	.15	.15	.20	.15	.20	.15	.20	.15
Independent	0	0	0	0	0	0	0	0	0	0	0

2.7.5 IADL Multipliers:

Level of Assistance	Meal Preparation	Housework	Communications	Shopping
Total Assist	1	1	1	1
Maximum Assist	1	1	1	1
Moderate Assist	.75	.75	.75	1

Level of Assistance	Meal Preparation	Housework	Communications	Shopping
Minimum Assistance	.5	.5	.5	1
Set-Up Assistance	.25	.25	.25	1
Independent	0	0	0	0

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 10 - Home & Community Based LTSS

Katie Beckett Program (210-RICR-50-10-03)

3.1 Overview

A. In 1982, Congress created a new Medicaid State Plan option under section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA), also referred to as the Katie Beckett (KB) provision, which enables otherwise ineligible children who have severe disabling impairments and/or complex health needs to obtain the services they need at home rather than in an institutional-setting in certain circumstances.

B. The scope of services KB-eligible children receive are also generally available under the Medicaid State Plan for Medicaid Affordable Care Coverage (MACC) group children with special needs eligible on the basis of the MAGI standard. Accordingly, all children are evaluated for MAGI-based eligibility first using the 261 percent of the Federal Poverty Level (FPL) standard. The KB provision applies to children who are not eligible for Medicaid through this pathway and, in doing so, assures some of Rhode Island's most vulnerable children will have access to critical home-based services which are not covered by most commercial and other third-party insurers.

3.2 Scope and Authority

Under the terms of the KB Medicaid State Plan option, a child must meet general and financial requirements as well as clinical criteria related to disability and the need for an institutional level of care. Prior to authorization of services, the State must also apply a federally required cost-effectiveness test to determine whether home-based services are as effective at meeting a child's needs at an equal or lower cost than care provided in an institutional setting.

3.3 Special Conditions

A. To qualify for Medicaid LTSS through the KB provision, a child must meet the general Medicaid requirements pertaining to residency, citizenship and immigration status. In addition, a child must be under nineteen (19) years of age and the following conditions must be met:

1. Financial Eligibility - Children seeking coverage for an institutional level of care at home who do not meet the eligibility criteria for MACC using the MAGI standard are subject to a financial eligibility review of income and resources using the SSI method for Community Medicaid, as set forth in Part 40-00-3 of this Title with the following exception --

a. Parental assets unavailable. When seeking Medicaid LTSS under the KB provision, the assets --income and resources - of the parent(s) or legal guardian(s) are deemed to be unavailable to the child applying for coverage. Accordingly, the financial eligibility determination is based on the child's income and resources. The standards that apply are the federal benefit rate relative to income and up to the medically needy limit of $4,000 in resources. This is the SSI method of treatment of income and resources that applies when a child with special needs is seeking coverage in an institutional setting.

b. Excluded expenses. In the calculation of countable income, any payments for in-home supportive services provided to the child which are covered by Medicaid or other federal, state or local government programs are excluded.

2. Clinical Eligibility - Upon application for coverage under the KB provision, a determination of clinical eligibility is made. There are two reviews included in this determination:

a. Disability review. The disability status of the child is reviewed using the applicable SSI criteria. Information provided by a child's primary health care practitioner and ancillary providers is used as the basis for this review. Appropriate consents and authorizations must be provided by the applicant's parents/guardian to ensure full access to health care records and evaluations required for the disability review.

b. Level of need. After the disability determination, the child's need for an institutional level of care using needs-based criteria related to functional and health status is considered.

c. Clinical determination. Based on the disability and level of care reviews, a determination is made on whether the child has disabling impairments and/or complex health needs that:

(1) Require the level of care typically provided in an institution; and

(2) The required services can be safely provided in the community.

3. The standards and criteria used to make the disability and level of care determinations are available on paper by contacting the Katie Beckett Unit at 401-462-0247 and on the EOHHS website at: http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/PeoplewithSpecialNeedsandDisabilities/Children/KatieBeckettEligibility.aspx

a. A child must meet federal criteria for childhood disability. Under Title XVI of the Social Security Act, a child under age 19 will be considered

disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that cause(s) marked and severe functional limitations, and that has lasted or can be expected to last for a continuous period of not less than 12 months, or can be expected to result in death. (A complete description of the Social Security Administration requirements can be found in *Disability Evaluation Under Social Security* - also known as the Blue Book).

b. As provided in 42 C.F.R. § 435.225 (b)(1), a child must require the level of care provided in a hospital (or psychiatric hospital), intermediate care facility for the intellectually disabled (ICF/ID), or nursing facility. Without appropriate interventions and supports (both at home and in the community), the child would either reside in an institution or be at immediate risk for institutional placement.

B. Cost Effectiveness Test - Both the decision on disability and level of care must be determined prior to the institutional versus home care cost-effectiveness comparison. Thus, the final step in determining eligibility under the KB provision is a comparison of the costs of providing the care a child needs at home versus in a health care institutional setting. If the costs of care at home are found to be higher, coverage under the KB provision must be denied.

1. Basis of comparison. The gross average monthly cost for providing care in the applicable health care institution - Nursing Facility, Intermediate Care Facility - Intellectual Disabilities (ICF-ID), or Hospital - as dictated by the child's needs is compared to the total gross monthly cost for allowed homecare services.

2. Institutional costs. This amount is determined on an annual basis and is set forth in the Medicaid Code of Administrative Rules, "Waiver Programs and Provisions" (Section 0396) by institution.

3. Allowed home care cost. The gross monthly costs for the following are included in this calculation:

a. Certified home health agency services, including skilled nursing; physical speech; occupational therapy; and home health aide services; and

b. Purchase or rental of durable medical equipment;

c. Home based therapeutic services; and

d. Minor assistive devices, minor home modifications, and other special equipment.

4. These costs are only taken into consideration if they are not covered or reimbursed by a third-party including, but not limited to, private commercial insurance and other publicly financed programs administered by a government agency or body, such as a school district.

5. Determination of cost-effectiveness. Upon taking these costs into consideration, cost-effectiveness is determined as follows:

a. KB Eligibility approved. If the total estimated cost of care in the home is less than the total estimated cost of care in the appropriate institution, home care is considered to be cost-effective, this special condition is met and a child who is otherwise eligible under the KB provision qualifies for the full scope of Medicaid benefits.

b. KB Eligibility denied. If the total estimated cost of services required to meet a child's needs at home exceeds the cost of institutional care, the child is ineligible under the KB provision, even if the child meets all other eligibility requirements.

6. Eligibility determinations for Medicaid / KB. Determinations for KB must take no longer than ninety (90) days from the date the completed application is received. The application remains open after that period if the Medicaid agency or its eligibility designee (DHS) or agents (application entities) are responsible for delays in the determination.

3.4 Continuing Eligibility

The financial eligibility of KB eligible children is renewed on an annual basis and when there are changes in state residence, the income and/or resources available to the child, living arrangements - that is, from home into an alternative health care setting -- or access to or coverage by a third-party payer. Clinical eligibility is also reviewed annually or when there is a change in health or functional status, unless it is determined that the frequency of reviews must be altered due to the unique needs/circumstances of the child.

3.5 Authorization and Delivery of Services

Upon determining a child is eligible for Medicaid under the KB provision, the necessary home-based services are authorized. Children without third-party coverage are enrolled in a RIte Care Plan in accordance with the provisions in the Medicaid Code of Administrative Rules, "RIte Care" and "Enrollment" (Sections 1309 and 1311). Children with alternative forms of coverage are provided services on a fee-for-service basis.

Chapter 50 - Medicaid Long-Term Services and Supports

Subchapter 15 - Personal Needs Funds

There are no Parts in this Subchapter.