



## RHODE ISLAND EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

### *Notice of Public Review of Rules and Public Hearing*

The Secretary of the Executive Office of Health & Human Services (EOHHS) has under consideration 12 regulations, including the *repeal* of 11 selected sections of the Medicaid Code of Administrative Rules (“MCAR”) as follows:

Existing MCAR Section #	Proposed New MCAR Section #	TITLE OF REGULATION TO BE REPEALED	LAST AMENDED
0351	1400	Overview of Medical Assistance	May 1, 2006
0352	1404	Characteristic Requirements	July 14, 2010
0354	1401	Resources Generally	July 1, 2008
0356	1410	Evaluation of Resources	December 30, 2008
0358	1405	SSI-Related Deeming of Resources	April 4, 2006
0362	1401	Income Generally	March 1, 2016 (E)
0364	1405	Treatment of Income	April 4, 2006
0366	1412	SSI-Related Deeming of Income	January 1, 2007
0368	1415	Flexible Test of Income	April 4, 2006
0370	1402	SSI-Related Coverage Groups	April 7, 2016
0372	1402	Special Treatment Coverage Groups	April 7, 2016

The EOHHS plans to repeal the 11 documents in the third column (noted above) in their entirety. Additionally, the EOHHS proposes to promulgate new regulations entitled, “**Section 1400: Integrated Health Care Coverage**” to replace and/or amend key provisions contained in these regulations.

With the enactment of the federal Affordable Care Act in 2010, Medicaid eligibility groups were reorganized into two categories based on whether their eligibility must be determined using the Modified Adjusted Gross Income (MAGI) standard or the more comprehensive requirements associated with the Supplemental Security Income (SSI) Program that consider income as well as certain characteristics – i.e., age, disability and blindness. For the purposes of clarity, the State has designated all MAGI-eligible populations as Medicaid Affordable Care Coverage (MACC) groups and consolidated all rules related to these groups in Chapter Section 1300 *et seq.* of the Medicaid Code of Administrative Rules (MCAR).

Beneficiaries subject to the more comprehensive SSI income standards – elders and adults with disabilities and beneficiaries receiving long-term services and supports (LTSS) – have been organized into a new broad coverage category referred to hereinafter as the “Integrated Health Care Coverage (IHCC)” groups.

New amendments appear in Section 1403 related to changes in the Medicaid application and renewal processes for affected individuals. Chapter 1400 also contains revised language to be consistent with the current Medicaid state plan. While Section 0352 is being repealed in its entirety, Section 1404.01(D)

incorporates by reference the Social Security Administration's Supplemental Security Income (SSI) disability criteria. Additionally, these criteria will be posted on the EOHHS website.

All of these regulations are promulgated pursuant to the authority contained in Rhode Island General Laws Chapters 40-8 (Medical Assistance); 42-7.2 (Executive Office of Health & Human Services) and 40-6 (Public Assistance Act); Title XIX of the Social Security Act; and the Medicaid Section 1115 Demonstration Waiver.

In the development of these proposed Regulations, consideration was given to the following: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small businesses in Rhode Island. No alternative approach, duplication or overlap, or impact upon small businesses was identified based upon available information.

In accordance with RIGL 42-35-3, the Secretary will hold a Public Hearing on all of these regulations on **Monday, June 20, 2016 at 10:00 a.m.** at which time and place all persons interested therein will be heard.

The Public Hearing will be convened as follows:

**Monday, June 20, 2016 at 10:00 a.m.  
Arnold Conference Center, Eleanor Slater Hospital  
John O. Pastore Complex, 111 Howard Avenue  
Cranston, RI 02920  
(Parking is adjacent to the building).**

All of these proposed documents, including those to be repealed, are accessible on the Rhode Island Secretary of State's website: <http://www.sos.ri.gov/ProposedRules/> or are available in hard copy upon request (401-462-1575 or RI Relay, dial 711). Interested persons should submit data, views, or written comments **by Monday, June 20, 2016** to: Elizabeth Shelov, Office of Policy and Innovation, Rhode Island Executive Office of Health & Human Services, Hazard Building, 74 West Road, Cranston, RI 02920 or [Elizabeth.Shelov@ohhs.ri.gov](mailto:Elizabeth.Shelov@ohhs.ri.gov).

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*Original signed by:*

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Elizabeth H. Roberts, Secretary  
Signed this 12<sup>th</sup> day of May 2016

**State of Rhode Island & Providence Plantations**

**Executive Office of Health & Human Services**



**Access to Medicaid Coverage under the Affordable Care Act**

**Section 1400:  
Medicaid Integrated Health Care  
Coverage**

**May 2016 (Proposed)**

**Rhode Island Executive Office of Health and Human Services**

**Access to Medicaid Coverage under the Title XIX of the Social Security Act**

**Medicaid Code of Administrative Rules Section 1400: Medicaid Integrated Care Coverage**

<b>Section #</b>	<b>Contents</b>	<b>Page Number</b>
1400 A.	<b>Overview of the Chapter:</b> <a href="#">Medicaid Integrated Care Coverage</a>	1
B.	<a href="#">Authority</a>	1
C.	<a href="#">Scope and Purpose</a>	1
D.	<a href="#">Applicability</a>	3
E.	<a href="#">“RI Bridges” Integrated Eligibility System and IHCC Groups</a>	4
F.	<a href="#">Scope of Coverage</a>	5
G.	<a href="#">Service Delivery Options</a>	6
1401 A.	<b><a href="#">Overview of the SSI Methodology Scope and Purpose</a></b>	6
B.	<a href="#">Definitions</a>	6
C.	<a href="#">SSI Methodology in Brief</a>	10
D.	<a href="#">General and Group-Specific Eligibility Requirements</a>	12
E.	<a href="#">Clinical Evaluations</a>	12
1401.01	<b><a href="#">SSI-Related Income and Resource Standards</a></b>	13
A.	<a href="#">Overview</a>	13
B.	<a href="#">Types of Income</a>	13
C.	<a href="#">Types of Resources</a>	15
D.	<a href="#">Income and Resource Standards</a>	15
1402.01	<b><a href="#">Integrated Care Coverage Groups – Community Medicaid</a></b>	18
A.	<a href="#">Overview</a>	18
B.	<a href="#">Authority</a>	19
C.	<a href="#">Scope and Purpose</a>	19
D.	<a href="#">EAD Eligibility Pathway – Low-Income Elders</a>	20
E.	<a href="#">Medically Needy Eligibility Pathway</a>	22
F.	<a href="#">SSI Recipients &amp; SSI-Related Groups with Protected Status</a>	23
1402.02 A	<b><a href="#">Medicare Premium Payment Program (MPPP) Overview</a></b>	29
B.	<a href="#">MPPP Coverage Groups</a>	29
C.	<a href="#">Medicare Part “D”</a>	31
D.	<a href="#">Application Process</a>	32
E.	<a href="#">MPPP Summary</a>	32
1402.03 A	<b><a href="#">Special Coverage Groups Overview</a></b>	34
B.	<a href="#">Breast and Cervical Cancer</a>	34
C.	<a href="#">Refugee Medicaid</a>	35
D.	<a href="#">Sherlock Plan</a>	36
E.	<a href="#">Emergency Medicaid</a>	37
1402.04 A	<b><a href="#">Preventive Level Services Scope and Authority</a></b>	37
B.	<a href="#">Scope of Services</a>	37
C.	<a href="#">Clinical Evaluation</a>	37
D.	<a href="#">Limits</a>	38
E.	<a href="#">Continuing Need</a>	38
1402.05	Summary: <a href="#">Financial Eligibility: IHCC Community Medicaid</a>	38
1403	<b><a href="#">Application Process for IHCC Groups</a></b>	39

<b>Section #</b>	<b>Contents</b>	<b>Page Number</b>
A.	<a href="#">Overview</a>	39
B.	<a href="#">Scope and Purpose</a>	39
C.	<a href="#">Application Access Points</a>	40
D.	<a href="#">Completing and Submitting the Application</a>	40
E.	<a href="#">Beneficiary Responsibilities</a>	43
1403.01	<a href="#">Application Review Process</a>	44
A.	<a href="#">Overview</a>	44
B.	<a href="#">Scope and Purpose</a>	45
C.	<a href="#">RI Bridges Conversion Process</a>	45
D.	<a href="#">Eligibility Options</a>	45
E.	<a href="#">General Rules</a>	46
1403.02	<a href="#">Renewal of Eligibility for IHCC Groups</a>	47
A.	<a href="#">Overview</a>	47
B.	<a href="#">Scope and Purpose</a>	48
C.	<a href="#">EOHHS Responsibilities</a>	48
D.	<a href="#">Beneficiary Responsibilities</a>	49
1404	<a href="#">General Eligibility Requirements</a>	50
A.	<a href="#">Scope and Purpose</a>	50
B.	<a href="#">Characteristic Requirements</a>	50
C.	<a href="#">Non-Financial Criteria</a>	50
D.	<a href="#">Good Cause for Non-cooperation</a>	56
1404.01	<a href="#">Disability Determinations</a>	56
A.	<a href="#">Scope and Purpose</a>	56
B.	<a href="#">Disability Standards for Community Medicaid</a>	56
C.	<a href="#">Eligibility Determination Sequence and Referral to the MART</a>	58
D.	<a href="#">Agency and Applicant Responsibilities</a>	59
1404.03	<a href="#">Formation of Financial and Eligibility Groups</a>	59
A.	<a href="#">Scope and Purpose</a>	59
B.	<a href="#">Medicaid Eligibility Group</a>	59
C.	<a href="#">Formation of the Financial Responsibility Group (FRU)</a>	60
1405.00 A	<a href="#">IHCC Groups: Treatment of Income Financial Eligibility Determination Overview</a>	61
B.	<a href="#">Definitions</a>	62
C.	<a href="#">EOHHS Responsibilities</a>	63
D.	<a href="#">Applicant Responsibilities</a>	64
1405.01	<a href="#">General Rules for the Treatment of Income</a>	64
A.	<a href="#">Scope and Purpose</a>	64
B.	<a href="#">Basic Income Counting Rules</a>	65
C.	<a href="#">Both Earned and Unearned Income Exclusions</a>	66
D.	<a href="#">Earned Income Exclusions</a>	67
E.	<a href="#">Unearned Income Exclusions</a>	68
F.	<a href="#">Lump Sum Income</a>	73
G.	<a href="#">Self-Employment Income</a>	74
H.	<a href="#">Availability</a>	75
1405.02 A	<a href="#">Income Deeming Overview</a>	76
B.	<a href="#">Definitions</a>	76
1410.00 A	<a href="#">Treatment of Resources in Financial Eligibility Determinations Overview</a>	82

<b>Section #</b>	<b>Contents</b>	<b>Page Number</b>
B.	<a href="#">Scope and Purpose</a>	83
C.	<a href="#">EOHHS Responsibilities</a>	84
1411.00	<b><a href="#">Resources in General</a></b>	86
A.	<a href="#">Scope and Purpose</a>	86
B.	<a href="#">Definitions</a>	86
C.	<a href="#">Types of Resources</a>	88
1411.01	<b><a href="#">Resource Review Process</a></b>	91
A.	<a href="#">Scope and Purpose</a>	91
B.	<a href="#">Process Rules</a>	91
C.	<a href="#">Mandatory Resource Exclusion</a>	94
D.	<a href="#">Special and Limited-Time Exclusions</a>	96
E.	<a href="#">Determination of Resource Eligibility</a>	97
1411.02	<b><a href="#">IHCC Group Resource Limits</a></b>	98
1412.00	<b><a href="#">Treatment of Resources – Community Medicaid</a></b>	99
A.	<a href="#">Scope and Purpose</a>	99
B.	<a href="#">Simplified Review Process</a>	99
C.	<a href="#">Non-Liquid Resource Exclusions</a>	99
D.	<a href="#">Liquid Resources</a>	102
1412.01	<b><a href="#">Resource Deeming</a></b>	104
A.	<a href="#">Scope and Purpose</a>	104
B.	<a href="#">Definitions</a>	104
C.	<a href="#">Deeming Rules</a>	104
1412.02	<b><a href="#">Excluded Resource Summary</a></b>	105
1415.00	<b><a href="#">Community Medicaid – Medically Needy Flexible Test of Income</a></b>	106
A.	<a href="#">Scope and Purpose</a>	106
B.	<a href="#">Process for Determining Flex Eligibility</a>	106
C.	<a href="#">Spendedown Calculation</a>	106
D.	<a href="#">Six-Month Spendedown Renewal</a>	107
E.	<a href="#">Allowable Expenses</a>	107
F.	<a href="#">Expense Exceptions</a>	108
1420.00	<b><a href="#">Retroactive Coverage</a></b>	108
A.	<a href="#">Scope and Applicability</a>	108
B.	<a href="#">Scope and Limits of Coverage</a>	109

## *Introduction*

These rules, Section 1400 of the Medicaid Code of Administrative Rules entitled, “Medicaid Integrated Care Coverage”, are newly adopted and promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 and 40-8.13 (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).

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

The rules in this chapter supersede Medicaid Code of Administrative Rules (MCAR), Sections 0351, 0352, 0354, 0356, 0358, 0362, 0364, 0366, 0368, 0370, 0372, 0374, 0375, 0380, and 0392, pertaining to the eligibility and benefits for beneficiaries who are subject to the Supplemental Security Income (SSI) standards last promulgated by EOHHS and filed with the Rhode Island Secretary of State.

## **Chapter 1400.00 Medicaid Integrated Health Care Coverage**

### **Section 1400 Overview of Medicaid Integrated Care Coverage**

#### **A. Overview of this Chapter**

With the enactment of the federal Affordable Care Act of 2010, Medicaid eligibility groups were reorganized into two categories based on whether their eligibility must be determined using the Modified Adjusted Gross Income (MAGI) standard or the more comprehensive requirements associated with the Supplemental Security Income (SSI) Program that consider income as well as certain characteristics – i.e., age, disability and blindness. For the purposes of clarity, the State has designated all MAGI-eligible populations as Medicaid Affordable Care Coverage (MACC) groups and consolidated all rules related to these groups in a chapter of the Medicaid Code of Administrative Rules (MCAR) – Section 1300 *et seq.*

Beneficiaries subject to the more comprehensive SSI income standards – elders and adults with disabilities and beneficiaries receiving long-term services and supports (LTSS) – have been organized into a new broad coverage category referred to hereinafter as the “Integrated Health Care Coverage (IHCC)” groups.

#### **B. Authority**

This chapter of rules entitled, “Chapter 1400 of the Medicaid Code of Administrative Rules: “Medicaid Integrated Health Care Coverage (IHCC)” is promulgated pursuant to the authority set forth in Rhode Island General Laws Chapters 40-8 (Medical Assistance); Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); and the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15). The rules in this chapter supersede Medicaid Code of Administrative Rules (MCAR), Sections 0352 through and 0372 pertaining to the eligibility and benefits for beneficiaries who are subject to the Supplemental Security Income (SSI) standard. The income and resource methodologies provided in this chapter apply to both Medicaid beneficiaries who qualify for long-term services and supports (LTSS) who are ineligible for the MACC group adults (see MCAR, Section 1305) as well as those who are eligible on the basis of age or a disability characteristic and income, but do not require LTSS. The rules pertaining to LTSS applicants and beneficiaries are located in MCAR, Chapter 1500.

#### **C. Scope and Purpose**

The purpose of this chapter is to establish the Medicaid Integrated Health Care Coverage (IHCC) group and to set forth, in plain language: the features of these groups, the SSI methodology for determining initial and continuing eligibility for coverage, service delivery options and the respective role and responsibilities of the Executive Office of Health and Human Services (EOHHS) and applicants and beneficiaries therein. Although the principal features and requirements of the SSI methodology applicable to all IHCC groups are set forth in this chapter, those that are specific to the Medicaid long-term services and supports (LTSS) eligibility groups

in this category are addressed in Chapter 1500, along with the administrative rules for LTSS more generally.

The EOHHS revised the rules on the SSI-methodology and the IHCC groups that deliver primary care services and consolidated them into this chapter to ensure they are accurate and up-to-date and reflect programmatic changes resulting from the following State and federal Medicaid initiatives:

- **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 waiver extension provided the authority and flexibility required to accelerate reforms designed to facilitate ease of access, promote the smart payment and purchasing of services, and encourage utilization of more cost-efficient services and delivery systems across populations, and in particular for the State’s most vulnerable beneficiaries – low-income elders and adults with disabilities. 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.
- **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 populations they cover. Rhode Island implemented all of the changes and took the option to expand coverage to adults, ages 19 to 64, who were NA for Medicaid in any other existing category. This chapter establishes administrative rules that apply ACA reforms related to eligibility and the application and renewal process to the IHCC groups to match those already in effect for MACC groups subject to the MAGI. They also set forth eligibility criteria that make it possible to evaluate applicants in the IHCC groups for multiple types of Medicaid coverage through a single application, including MAGI-based coverage for adults, to facilitate ease of access, maximize the available care options, and provide greater choice.
- **RI Bridges** – “RI Bridges” is the State’s integrated health and human services eligibility system launched in July 2016. RI Bridges 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 every facet of the application, eligibility determination and enrollment process, RI Bridges also enables the State to conduct the multi-tiered evaluation of eligibility that begins with the coverage group with the highest income standard and least restrictive requirements, moving from there to determine eligibility for each of the remaining coverage groups that have more specialized and/or restrictive requirements.

This specific section of chapter provides an overview of the IHCC groups and the process for determining their eligibility for Medicaid health coverage and/or other forms of assistance.

## D. Applicability

On and after the effective date of these rules, the provisions of this chapter govern the eligibility pathways that use the SSI methodology in whole or in part to determine whether applicants and beneficiaries in the following IHCC groups qualify Medicaid health coverage:

- (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/\$6,000 for a couple.
- (2) **Medically Needy** – Elders and persons with disabilities who have high medical expenses and must spend or contribute excess income and/or resources to the cost of care to obtain/retain Medicaid eligibility. Includes both LTSS and non-LTSS beneficiaries and requirements vary accordingly.
- (3) **Supplemental Security Income (SSI) Recipients** – All persons receiving SSI cash assistance based on age or 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. Although the financial criteria used to evaluate Medicaid eligibility for persons of all ages is the same, criteria for determining disability and the scope of coverage an SSI-eligible beneficiary receives varies by age. Accordingly, program specific provisions for SSI recipients twenty-one (21) and older are included in this section along with those applicable to other adults in this coverage category. Such provision for Medicaid beneficiaries under 21 are located in the sections pertaining to coverage for children and families in Chapter 1300 MCAR.
- (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 as well EAD who meet the special living arrangement requirements for SSP set by the State.
- (5) **SSI-relate Groups** – This group – sometimes referred to SSI- lookalikes – includes persons who the meet age or disability criteria for SSI, but are or become NA for cash assistance due to a change in relationship status or living arrangement, participation in work incentive programs, receipt of Social Security benefits resulting from the retirement, disability, or death of a parent or spouse, or federal policy shifts that alter eligibility for a limited period or populations. To protect or assure Medicaid eligibility for members of these coverage groups, federal law requires the EOHHS to apply special income disregards when determining EAD eligibility and/or accept “deemed” SSI status that confers automatic eligibility.
- (6) **Medicaid Premium Payment Program (MPPP) for low-income Medicare beneficiaries** – The MPPP is for Medicare beneficiaries with income at or below 135% of the FPL. This Program provides financial help through Medicaid to assist in paying Medicare costs including premiums, deductibles, and/or coinsurance in amounts that vary

depending on income and resources. For certain low-income MPPP beneficiaries with limited resources, full Medicaid coverage is also available.

- (7) **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.
- (8) **Refugee Medicaid** – 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.
- (9) **Emergency Medicaid** – Medicaid health coverage available to non-citizens in emergency situations who meet all the general and income requirements for coverage with the exception of immigration status.
- (10) **Sherlock Plan for Working Adults with Disabilities** – The State’s program for working adults with disabilities. Sherlock provides Medicaid health coverage and/or services and supports to persons with disabilities who are working, and who otherwise meet the disability criteria for EAD (Community Medicaid) or LTSS Medicaid, and have income up to two-hundred and fifty percent (250%) of the FPL and resources of less than or equal to \$10,000 individual/\$20,000 couple.
- (11) **IHCC Group LTSS Applicants/Beneficiaries** – The coverage group consists of new applicants seeking Medicaid-funded LTSS and current IHCC group beneficiaries who develop a continuous need for the level of care typically provided in an institution (hospital, nursing facility, intermediate care facility for person with intellectual disabilities). Beneficiaries eligible in the MACC groups (see MCAR, Chapter 1300) who require LTSS are not subject to the SSI methodology.

## **E. RI Bridges Integrated Eligibility System and IHCC Groups**

With the implementation of RI Bridges, all IHCC group members have the options of applying on-line using a self-portal, submitting a completed paper application, or in-person by visiting one of the field offices of the RI Department of Human Services (DHS). RI Bridges evaluates the eligibility of applicants for a wide-range of health and human services programs in addition to Medicaid, upon request, without requiring the completion of multiple forms. The new integrated system also makes the following important changes to the application and eligibility determination process:

- (1) **Coverage Group Options** – To maximize choice and ease of access, the RI Bridges system 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** – RI Bridges 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 Active Eligibility Renewal** – The eligibility renewal process has also been changed in RI Bridges to ease the burden on beneficiaries. The State’s new passive renewal process has eliminated the requirement that beneficiaries reapply for an eligibility redetermination on an annual basis. Instead, beneficiaries are required to review the eligibility information known about a beneficiary in RI Bridges and notify the EOHHS 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 is set forth in Section 1403.01.

## **F. Scope of Coverage**

The scope of coverage members of the IHCC groups is 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 certain assistance in paying premiums, co-pays, and cost-sharing.

- (1) **Premium Assistance/and Financial Help** – Dual Medicare and Medicaid beneficiaries may receive full Medicaid health care services and supports and/or financial help paying for Medicare. The scope of benefits dual eligible beneficiaries receive depends on coverage group and income and resources. Premium assistance is also available for beneficiaries who have access to employer sponsored insurance through the RIte Share Premium Assistance Program as set forth in Section 1312.
- (2) **Health Care Services and Supports** – With the exception of Medicare Premium Payment Program participants, beneficiaries eligible under this section 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 and supports. MCAR, Section 1475 identifies the scope of covered services available to beneficiaries through the managed care and fee-for-service delivery options available to members of each IHCC group.
- (3) **LTSS** – Medicaid LTSS includes health supports, personal care, and social services in an institutional or home and community-based setting. The specific types of Medicaid LTSS are described in MCAR, Section 1500. 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 other MACC or IHCC groups. In addition, the scope of LTSS a person receives depends on his or her need for a particular level and kind of care typically provided in one of three health care institutions – a nursing facility (NF), intermediate care facility for persons with intellectual disabilities (ICF-ID), or a hospital.
- (4) **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 MCAR, Section 1500, to obtain the coordinated services they need across the care continuum through a single Medicaid health plan. Section 1475 outlines these options and the process for plan selection and enrollment.

- (5) **Retro-Active Eligibility** – Up to three (3) months of Medicaid retroactive coverage is available for all IHCC group members. To qualify, the State must determine that the persons would have met the applicable eligibility criteria for their coverage group if they had applied during the retroactive period. The State provides reimbursement only for Medicaid covered services, however. The provisions in MCAR, Section 1420 explain the process for obtaining retroactive coverage in greater detail.

**G. Service Delivery Options**

The service delivery options for IHCC group members are dictated in large part by the type of Medicaid health coverage and eligibility pathway. See MCAR, Section 1475.

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

**Section 1401 Overview of the SSI Methodology**

**A. Scope and Purpose**

To determine the Medicaid eligibility of the IHCC groups who do not qualify for SSI, Rhode Island, like most states, took the option under federal law to apply the SSI methodology rather than one of the State’s own design that uses more restrictive criteria – e.g., lower income or asset limits. The State has used the flexibility federal Medicaid law allows to modify SSI standards to expand eligibility.

**B. Definitions**

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

“**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 of the SSI methodology as set forth in this chapter or Chapter 1500.

“**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.

L. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).

**“Categorical Eligibility”** means applicants/beneficiaries who have Medicaid eligibility based on set income and resources guidelines established under the state plan in accordance with Title XIX.

**“Community Medicaid”** means the term used to refer to IHCC groups that are provided with comprehensive Medicaid health coverage that does not include more than thirty (30) days of LTSS.

**“Elders and Adults with Disabilities (EAD)”** means the Medicaid Integrated Health Care Coverage group established by §40-8.5 for adults with an SSI characteristic related to age (elders 65 years of age or older) or disability who have income at or below one hundred percent (100%) of the FPL and do not qualify for SSI cash assistance.

**“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.

**“Federal Benefit Rate (FBR)”** means the amount of the monthly cash assistance authorized for the recipients of the SSI program.

**“Financial Responsibility Unit (FRU)”** means the group of persons, typically living in the same household as the applicant/beneficiary, whose *income and resources* are considered available when determining financial eligibility.

**“Full Dual Eligible”** means a fully eligible Medicare beneficiary who qualifies for Medicaid health coverage based on income and resources.

**“IHCC Group Eligibility Standard”** means the income and resource standards used as the basis for determining initial and continuing Medicaid eligibility for each coverage group.

**“Integrated Health Care Coverage (IHCC) Groups”** 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). This group includes beneficiaries eligible for community Medicaid (non-long-term care), Medicaid-funded LTSS and the Medicare Premium Payment Program (MPPP).

**“Long-Term Services and Supports (LTSS)”** means a spectrum of services covered by the Rhode Island Medicaid program that are required by individuals with functional impairments and/or chronic illness, and includes skilled or custodial nursing facility care, as well as various home and community-based services.

**“Managed Care Arrangement (MCA)”** means a system that uses capitated financing to deliver high quality services and promote and optimize health outcomes through a medical home. Such an arrangement also includes services and supports that optimize the health and independence of beneficiaries who are determined to need or be at risk for Medicaid funded LTSS. MCA include

any arrangement under which an MCO is granted some or all of the responsibility for providing and/or paying for long-term care services and supports through a contractual agreement with the Medicaid program.

**“Managed Care Organization”** 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.

**“Medicaid Affordable Care Coverage (MACC) Groups”** means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility as outlined in MCAR, Section 1300 *et seq.*

**“Medicaid Assessment and Review Team or MART”** means the unit within EOHHS responsible for determining whether a person meets the clinical disability standards for eligibility as a low-income elder or adult with disabilities, who does not require Medicaid LTSS.

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

**“Medicaid Eligibility Group”** means the persons in a household whose *needs* are considered when determining eligibility. When using the SSI methodology, the Medicaid eligibility is always an *individual* (single applicant only) or *couple* (spouses living together even if only one is applying). For LTSS, the Medicaid eligibility group is always

**"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 prevent a decremental change in either medical or mental health status.

**“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, Medicaid eligibility and coverage for members of this group occurs 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.

**“State Supplemental Program or SSP”** means the optional State-funded cash assistance program for low-income elders and adults with disabilities who receive SSI or meet the EAD financial requirements and reside in a certain living arrangement. SSP recipients are categorically eligible for Medicaid if they meet the SSP eligibility criteria, even when NA for SSI.

**“Partial Dual Eligible”** means a low-income Medicare beneficiary who is ineligible for full Medicaid health coverage due to excess income and resources, but who qualifies to receive financial assistance with Medicare premiums and, some cases cost-sharing, through the State’s Medicare Premium Payment Program (MPPP).

**“Partial Dual Eligible Plus”** means a low-income Medicare beneficiary with resources below 300% of the SSI limit who qualifies for full Medicaid health coverage based on income in any coverage group – IHCC or MACC – and financial assistance with Medicare premiums and/cost-sharing through the MPPP.

**“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, home care, day care, etc.).

**“Rhody Health Options”** means the capitated managed care delivery system operating under contract with EOHHS to manage and coordinate the Medicaid covered services and supports for Medicaid beneficiaries eligible for the Integrated Care Initiative (ICI) Phase I.

**“Rhody Health Partners (RHP)”** means the Medicaid managed care service delivery option for adults in the IHCC groups that provides primary/acute and specialty care through a medical home that focuses on prevention and promoting healthy outcomes. The rule for RHP for adults 19-64 in the MACC groups is located in MCAR sections 1310 and 1311.

**“Resource”** means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for support and maintenance.

**“RI Bridges”** is the State’s fully integrated health and human services computer eligibility system, implemented in July 2016.

**“RSDI”** means Retirement, Survivors, and Disability Insurance and stands for the three of the types of benefits that the U.S. Social Security Administration pays to qualified beneficiaries. Another name for the Social Security program is "Old Age, Survivors and Disability Insurance Program," or OASDI.

**“Section 1619(a)”** means the provision in the Title II of the Social Security Act that extends special SSI cash to recipients whose earnings preclude eligibility for regular SSI cash assistance. Such recipients are afforded SSI protected status and maintain categorical eligibility for Medicaid even if they have excess income.

**“Section 1619(b)”** means the provision in the Title II of the Social Security Act that extends Medicaid coverage to anyone whose earnings, although high enough to preclude eligibility for regular SSI cash benefits or special SSI cash benefits under section 1619(a), may not be enough for health care coverage.

**“Sherlock Plan”** means the State’s program for working adults with disabilities – both Community and LTSS Medicaid-eligible – who have earnings and resources that otherwise would precluded them from obtaining Medicaid health coverage. Sherlock beneficiaries must pay either a premium or cost share to maintain coverage while working.

**“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 Agency for the Supplemental Security Income program.

**“SSI-Related Groups”** means the class of beneficiaries who have protected or deemed status and retain categorical eligibility for Medicaid even though they are no longer eligible for SSI cash assistance as well as “SSI lookalikes.”

### **C. SSI Methodology in Brief**

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

- (1) **Financial Determination** – To determine countable income and available resources, which are used as the basis for financial eligibility, the methodology includes a multi-step calculation including some or all of the factors below depending on coverage group and, consisting of the components below. More detailed information about the SSI methodology and associated income and resource standards across IHCC groups are contained in Section 1401 herein. The specific requirements for treatment of income and resources for the non-LTSS, Community Medicaid IHCC groups are contained in Section 1405.
  - (a) Formation of the Financial Responsibility Unit (FRU). The FRU – previously known as the financial unit – consists of the persons, typically living in the same household as the applicant/beneficiary whose income and resources are considered available when determining financial eligibility. The FRU includes applicants as well as non-applicant spouses, dependents and, in some instances, adult siblings who may not be seeking Medicaid eligibility or may not qualify and are ineligible for Medicaid on the basis of a requirement other than income. These non-applicant members of the FRU are sometimes referred to as “ineligible” or “disqualified” as their income is considered, but not their need for services
  - (b) Identification of the Medicaid Eligibility Group. The Medicaid eligibility group consists of individuals whose needs are included in the eligibility determination for SSI-related Medicaid in accordance with rules set forth below. To determine eligibility, the countable income and resources of the FRU are compared to the maximums based on the size of the Medicaid group. For the IHCC groups, the Medicaid eligibility is always one (individual) or two (couple). Other members of the household who are members of the FRU are considered for deeming purposes, but are not part of the Medicaid eligibility group.
  - (c) Evaluation of Income. All forms of income are reviewed and any excluded sources of income for Medicaid eligibility purposes are removed from consideration.
  - (d) Application of Disregards. Standard disregards are applied (the first \$20 of unearned income and first \$65 of earned income and 50% reduction of the remainder) as are coverage group or program-specific disregards.

- (e) Resource Assessment. Resources are reviewed and the value of any resources that are available and that have not been excluded are counted.
  - (f) Deeming – Non-LTSS Only. The income and/or resources of a member of the household are considered to be available to the applicant and are included in the financial eligibility determination.
  - (g) Pre-eligibility Evaluation of Medical Expenses – LTSS Only. Involves the evaluation of medical expenses that may reduce available resources to levels at or below the limits for a specific coverage group.
  - (h) Post-eligibility Treatment of Income (PETI) – LTSS Only. The recalculation of income without certain disregards and exclusions for the purposes of determining the financial liability of an LTSS beneficiary.
- (2) **Characteristic Requirements** – As a result of the historical tie to the SSI program, members of the IHCC groups have to have certain characteristics related to age and/or disability to qualify for Medicaid health coverage. General characteristic requirements that drive eligibility are as follows:
- (a) Age. To be eligible based on an age characteristic, a person must be sixty-five (65) years or older. Applicants/beneficiaries who meet the age characteristic and the general eligibility and financial requirements are NOT subject to a clinical determination of disability unless seeking LTSS.
  - (b) Disability. A person between the ages of 19 and 64 seeking eligibility based on a disability generally must meet the SSI criteria related to work, adjusted for the specific coverage group or the LTSS clinical/functional criteria focusing on the need for an institutional level of care (e.g., care provided in a hospital, nursing facility (NF), or intermediate care facility for persons with intellectual disabilities (ICF-ID). All children and youth under 21 seeking medically needy or Katie Beckett eligibility are subject to different disability criteria than adults.
  - (c) Blindness. Persons who are blind who have income up to the SSI level are categorically eligible for Medicaid even when they do not qualify for cash assistance. Federal regulations require states, like Rhode Island, who have expanded income eligibility higher than this level, to evaluate these applicants using the work-related disability criteria.
  - (d) Preventive Level of Need. Beneficiaries who meet the age or disability criteria for Community Medicaid and meet clinical criteria indicating they are at risk for Medicaid LTSS are eligible for an additional set of limited preventive services.
- (3) **LTSS 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 an 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, current MACC and IHCC group beneficiaries and new applicants must meet three core eligibility factors:

- Institutional Level of Care. Anyone seeking Medicaid LTSS must meet the clinical/functional disability criteria specific to a level of care in a NF, ICF-ID or a hospital. Under the State’s Section 1115 demonstration waiver, a preventive level of services is available for Community Medicaid beneficiaries who are at risk for an institutional level of care.
- Financial Requirements. All LTSS applicants/beneficiaries are subject to income and resource evaluations that consider the cost of care, service setting, spousal financial security and the transfer of assets; and
- Pre-eligibility Evaluation of Medical Expenses (PEME) and Post-eligibility Treatment of Income (PETI). The PEME process allows applicants/beneficiaries to reduce excess resources by taking into account certain medical expenses; the PETI determination process establishes “beneficiary liability” which is the amount of excess income the LTSS beneficiary must pay toward the cost of care to maintain financial eligibility.

New applicants for LTSS are evaluated for eligibility using a modified version of the SSI methodology that excludes deeming and uses a unique set of disregards. The specific requirements related to the LTSS eligibility pathways are located in MCAR, Section 1501.

#### **D. General and Group-Specific Eligibility Requirements**

All applicants/beneficiaries in the IHCC groups must also meet the general eligibility requirements related to residency, citizenship, third-party coverage and cooperation. The IHCC general eligibility requirements for IHCC Community Medicaid are specified in Section 1404 as well as in the sections related to specific coverage group. Documentation related to both financial and clinical eligibility factors is specified in these same sections.

#### **E. Clinical Evaluations**

A clinical evaluation to determine the presences of a disabling impairment based on SSA criteria or a functional disability and need for an institutional level of care are important components of the eligibility process for most of the IHCC groups with members under age 65 and for all applicants for LTSS. The criteria and processes for making these determinations may vary considerably in accordance with the type of Medicaid health coverage provided members of a particular IHCC group. The following identifies the entity responsible for clinical evaluations and the associated coverage groups:

- The SSA conducts disability determinations for SSI and SSP recipient.
- The Medicaid Assessment and Review Team (MART) uses the SSA criteria to evaluate EDA applicants for disability. The MART only makes a disability determination

subsequent to the SSA. Therefore, an applicant must show that that he or she applied for and was found ineligible for SSI, and/or other federal and State assistance programs for persons with disabilities.

- The Office of Medical Review (OMR) uses clinical/functional disability criteria to evaluate the need an applicant/beneficiary has for an institutional level of care in a nursing facility or hospital.
- Community Medicaid beneficiaries may be determined to be at risk for LTSS and eligible for a limited range of home and community-based services based on the criteria for a preventive level of need set forth in Section 1501.01 Such determinations are also made by OMR.
- The Office of Children and Family Health evaluates whether a child seeking Katie Beckett eligibility has a disabling impairment requiring an institutional level of care. The requirements for Katie Beckett eligibility are set forth in Chapter 1501.030
- The Division of Developmental Disabilities of the RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) determines whether a beneficiary meets the clinical criteria set in State law for a determination of disability associated with the level of care an Intermediate Care Facility for persons with Intellectual/Developmental Disabilities (ICF-ID). BHDDH also determines whether certain behavioral health disabling conditions qualify for specialized services and/or a hospital level of care.

## **Section 1401.01 SSI-Related Income and Resources Standards**

### **A. Overview**

The basic tenets of the SSI methodology are established in the rules for determining eligibility for SSI set forth in the Social Security Administration's, *Program Operations Manual System (POMS)*, at sections SI 00810.00 to SI 00870.000. Federal regulations pertaining to Medicaid require states to use the two central measures in the SSI methodology – income and resources – when determining financial eligibility for members of the ICHH groups. Federal regulations also afford the states the flexibility to vary these standards as long as they are not applied in way that is more restrictive than the way they are used in the SSI program. This section describes the SSI-based income and resource standards for the IHCC groups as they have been adapted to make full use of the State's flexibility under applicable federal regulations and the Rhode Island's Section 1115 demonstration waiver.

### **B. Types of Income**

For the purposes of determining IHCC financial eligibility, income is anything received in cash or in-kind that can be used to meet the needs for food, clothing or shelter. In-kind income is not cash, but is actually food, clothing, or shelter, or something of use in obtaining these necessities. An

item is not considered income if it is solely for the purpose of food or shelter or obtaining food or shelter.

Earned and unearned income is considered when determining an individual's and couple's financial eligibility.

(1) **Earned Income** – Earned income may be in cash or in-kind. Earned income is counted as earned income when received or would have been received except that the person seeking benefits decided to postpone receipt rather than when earned. This recognizes that the time between earning and receiving income may extend for long periods in some instances. For the purposes of the SSI methodology, earned income consists of the following:

- Wages;
- Net earnings from self-employment;
- Payments or refunds of earned income tax credits;
- Payments for services performed in a sheltered workshop or work activity.

In a program based on the current need, the relevant time is when income is received.

(2) **Unearned Income** – Unearned income is that which is not earned, whether cash or in-kind. Some types of unearned income are:

- Deemed income;
- Income from legally liable relatives;
- Workers' Compensation;
- Annuities, pensions, and other periodic payments;
- Alimony and support payments;
- Dividends, interests and royalties;
- Rents;
- Benefits received as the result of another's death to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the recipient;
- Prizes and awards;
- In-kind support and maintenance (ISM);
- Life insurance proceeds; and
- Gifts and inheritances.

### C. Types of Resources

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 IHCC group eligibility, the following distinctions apply:

- Liquid resources are any resources in the form of cash or in any other form

which can be converted to cash within 20 work days.

- Non-liquid resources are any resources which are not in the form of cash and which cannot be converted to cash within 20 workdays.

Not all of a person's resources are countable assets for Medicaid eligibility purposes. An asset that is not a resource does not count against the IHCC group resource limits (while a resource may count). Certain standard exclusions also apply. Countable liquid assets that typically do count are stocks, bonds, cash value of insurance policies, bank accounts, certificates of deposit, and IRA's. Any other real estate besides the home of the applicant/beneficiary is also counted. Section 1410 explains the treatment of resources in general and in relation specifically to IHCC Community Medicaid. LTSS provisions are located in Chapter 1500.

#### D. Income and Resource Standards

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

- (1) **Monthly Federal Benefit Rate (FBR)** – The FBR is based on the SSI monthly cash payment adjusted for living arrangement and is used for deeming purposes for the IHCC groups when applicable. The difference between is the amount used to determine whether the deeming of income applies – see Section 1405.02. The FBR is also the basis for the income eligibility cap for LTSS in certain circumstances, as indicated in MCAR, Section 1510.

<b>Monthly Federal Benefit Rate (FBR) - 2016</b>	
<b>Living Arrangement</b>	<b>Monthly Payment</b>
Individual - Own Home	\$ 733
Couple - Own Home	\$ 1,100
Individual - Home of Another	\$ 488.67
Couple - Home of Another	\$ 733.34
<b>"Difference Between"</b>	
Couple and Individual - Own Home	\$ 367
Couple and Individual - Home of Another	\$ 244.67
<b>"Double the FBR"</b>	
Individual - Own Home	\$ 1,466
Individual - Home of Another	\$ 977.34
Couple - Own Home	\$ 2,200
Couple - Home of Another	\$ 1,466.68

- (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:

<b>Optional State Supplement Payment (SSP) Limits: 2016</b>		
<b>Living Arrangement</b>	<b>Individual</b>	<b>Couple</b>
Living in a residential care and assisted living facility – SSP Category D	LTSS 300% SSI Level \$2,199  Community Medicaid \$1,065	Limits are for individual only
LTSS Living in a Community Support Living Program residence – Category F	LTSS only \$2,199	Not Applicable
LTSS Beneficiary in residing in institutional – setting (NF, ICF-ID, Hospital) –	\$2,199	Not Applicable
Living in own household	\$722.92	\$1,179.93
Living in household of another	\$540.59	\$830.64
Living in a Medicaid-funded Institution	\$90	Not Applicable

(3) **Medically Needy (MN) Monthly Income Standards for Community Medicaid** – Also known as the FLEX, this eligibility category is reserved for applicants with excess income and high health care expenses are able to spenddown to the applicable income limit. Under the RI Medicaid State Plan Medically Needy coverage is available to elders and adults with disabilities, children and pregnant women. Parents/caretakers and adults 19-64 in the MACC groups are ineligible on that basis and must seek MN coverage if needed by applying through the EAD pathway. The Medically Needy Standards have two components:

- (a) **Medically Needy Income Limit (MNIL).** The MNIL provides the income eligibility threshold and is based on the limit set for the specific coverage group. The MNIL for EAD is set below the applicable income limit because federal law requires that it be no higher than 133 percent of the maximum state Aid to Families and Dependent Children (AFDC) level, as of July 16, 1996, for a family of two without income or resources. Although AFDC was replaced in 1996 by the Temporary Assistance to Needy Families (TANF) program, now known as RI Works, the Medicaid MNILs remain linked to the old AFDC standards. For beneficiaries who would otherwise qualify for Medicaid in the MACC groups using the MAGI (see Chapter 1300), the MNIL is the income limit plus the five (5) percent disregard, when applicable, required by the ACA.
- (b) **Spenddown Threshold.** The MN spenddown threshold is the basis for determining how much a beneficiary must have in allowable health expenses per month during the 6 month MN coverage period to retain eligibility. Federal regulations at 42 CFR 435.726 (c)(1) and 435.601 (d)(2) require any state that uses less restrictive eligibility standards and methods than SSI to establish the MN spenddown threshold level at highest FPL income limit for the associated coverage group, less any disregards.

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

<b>Medically Needy Monthly Income Eligibility Standards – Community Medicaid 2016</b>		
<b>Coverage Group</b>	<b>Medically Needy Income Limit</b>	<b>Spenddown Threshold</b>
Elders and Adults with Disabilities	\$867 (I)	100% FPL
	\$902 (C)	
Pregnant Women	258% FPL	253% FPL
Children Under Age 19	266% FPL	261% FPL

<b>Medically Needy Monthly Income Limits Adjusted for Family Size - 2016</b>			
1 Person	\$ 867.00	5 Persons	\$ 1,442.00
2 Persons	\$ 908.00	6 Persons	\$ 1,625.00
3 Persons	\$ 1,125.00	7 Persons	\$ 1,783.00
4 Persons	\$ 1,283.00	8 Persons	\$ 1,967.00

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

<b>Federal Poverty Level Income Limits All IHCC Groups – 2016</b>	
<b>Coverage Group</b>	<b>FPL Limit (Monthly Amount)</b>
Elders and Adults with Disabilities (EAD)	100%
	\$981 (Individual)
	\$1,328 (Couple)
Community Medicaid Medically Needy	Above 100% FPL Spenddown to \$867
QMB	100%
	\$981 (Individual)
	\$1,328 (Couple)
SLMB	120%
	\$1,197 (Individual)
	\$1,613 (Couple)
QI	135%
	\$1,345 (Individual)
	\$1,813 (Couple)
Sherlock Plan	250%
	\$2,475 (I)
	\$3,338 (C)
LTSS Pathway	SSI Eligible – up to 300% SSI Level \$2,199

<b>Federal Poverty Level Income Limits All IHCC Groups – 2016</b>	
<b>Coverage Group</b>	<b>FPL Limit (Monthly Amount)</b>
	EAD Eligible – 100% FPL to 300% SSI Level \$981 - \$2,199
	MACC Eligible 133% FPL (with possible 5% disregard) to 300% SSI Level \$1,305 - \$2,199
LTSS Medically Needy	Above \$2,199 up to the 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% of the FPL to use the same resource limits in effect for Medically Needy eligibility.

<b>Resource Standards for IHCC Groups</b>	
<b>Coverage Group</b>	<b>Limits</b>
Community Medicaid – EAD and Medically Needy	\$4,000 (I) \$6,000 (C)
SSI – Related/Protected Status	Varies by coverage group
SSP – State Determination	\$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 (I) \$20,000 (C)
LTSS – SSI	\$2,000
LTSS – Special Income/HCBS	\$4,000
LTSS – Medically Needy	\$4,000
MPPP	Varies – See Section 1402.02

## **Section 1402. Integrated Care Coverage Groups – Community Medicaid**

### **A. Overview**

Federal law, the State’s Medicaid State Plan and Section 1115 waiver authorize multiple eligibility pathways for low-income elders and persons with disabilities in the IHCC category and, to a more limited extent, the MACC groups for parents/caretakers and adults. As the MACC eligibility pathways are not tied to SSI standards, the age and disability characteristic requirements do not apply and are secondary to other factors such as income, relationship and access to other forms of health insurance coverage. For a person 65 or older, MACC eligibility is available, but only if a parent/caretaker of a Medicaid eligible child.

The IHCC groups established in this section thus provide the principal Medicaid eligibility pathways for elders and adults with disabilities who have SSI or an SSI characteristic.

## B. 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.G.L. § 40-8.5. Many of the core eligibility requirements associated with this group, including those pertaining to medically needy coverage, pre-date both this law’s enactment and federal approval of the State’s 1115 waiver. As a result, they are dispersed in various other provisions of Chapter §40-8 that deal more generally with SSI-related eligibility, particularly for LTSS, instead of located in a single statute.

The specific provisions applicable to each IHCC group are identified, where appropriate, in the corresponding sections of this chapter. Authorities that apply to LTSS-only are identified in Chapter 1500.

## C. Scope and Purpose

This purpose of this rule is to establish and describe the coverage groups subject to the SSI methodology for determining Medicaid eligibility, effective on and after July 11, 2016. The summary table below shows the key distinguishing features in each category that provide Medicaid health coverage followed by specific provisions related to each.

<b>IHCC Groups Community Medicaid Key Eligibility Features</b>		
<b>IHCC Group</b>	<b>Special Treatment or Eligibility Factor</b>	<b>Agency Responsible for Determining Eligibility</b>
Low-income Elders and Adults with Disabilities (EAD)	Chief Coverage group for persons 65 and older or living with a disability and ineligible for SSU	EOHHS
SSI Recipients	Automatically eligible for Medicaid	SSA
SSP Recipients	Living Arrangement	SSA and EOHHS
Pickle Amendment	Income –RSDI COLA Disregards	EOHHS
1619 (a) Adults	Income, Resources, Employment	SSA
Medicaid While Working	Income, Resources, Employment	SSA
Protected Surviving Spouses	Income –RSDI Benefit Disregard	EOHHS
Adult Children with Disabilities	Income –RSDI Benefit Disregard	EOHHS
Divorced/Surviving Spouses with Disabilities	Income –RSDI Benefit Disregard	SSA

<b>IHCC Groups Community Medicaid Key Eligibility Features</b>		
<b>IHCC Group</b>	<b>Special Treatment or Eligibility Factor</b>	<b>Agency Responsible for Determining Eligibility</b>
SSP Recipients, 12/73	Special statutory eligibility	EOHHS
Divorced/Surviving Spouses with Disabilities – Actuarial Changes	Special statutory eligibility	SSA
Breast and Cervical Cancer Screening and Treatment	CDC Screening Guidelines for Breast and Cervical Cancer	DOH
Refugee Medicaid Assistance	Federal Office of Refugee Settlement – designation of “refugee” immigration status	EOHHS
Sherlock Plan	Buy-in for Working Disabled Adults that do not qualify for SSI-protected status groups	EOHHS

The Medicare Premium Payment Program is excluded and addressed separately in Section 140 due to its unique features.

#### **D. EAD Eligibility Pathway – Low-income Elders and Adults with Disabilities**

Under Section 1396a of the Social Security Act, states have the option under the Medicaid State Plan of expanding eligibility to elders and adults with disabilities from the SSI standard up to 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.” Under federal law, there are certain restrictions that apply to coverage in this group:

- A person who would otherwise be eligible on the basis of blindness alone is not EAD eligible unless he or she meets the disability criteria.
- The income limits are rigid; there is no flexible test of income. As result, medically needy coverage is attached to an income standard below 100% of the FPL. As is explained in greater detail in Section 1415, the medical needy pathway for EAD Community Medicaid requires beneficiaries to meet a lower income limit to qualify for coverage, though the spenddown threshold is the same as eligibility standard allowed for EAD eligibility. Children and pregnant women seeking medically needy coverage have income limits and spenddown requirements to the applicable MACC groups.

These limitations aside, 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 cash assistance. The EAD eligibility pathway is open to applicants/beneficiaries who meet these requirements and are eligible for or enrolled in Medicare, or have other forms of third-party coverage. It also serves as the basis for determining Medicaid eligibility for many of the SSI-related coverage groups and certain LTSS eligibility categories. Coverage group features are as follows:

(1) **Eligibility Criteria** – To qualify for Medicaid coverage through the EAD eligibility pathway, an applicant must meet the general eligibility requirements related to residency, citizenship and cooperation set forth in Section 1404 and the following:

(a) **Characteristic Requirements.** An applicant must be without SSI and –

- Age. Sixty-five (65) and older; or
- Disability. Determined by the Medicaid Assessment and Review Team (MART) to meet the applicable SSI disability; or
- 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 have income above the SSI standard are subject to a MART disability determination.

(b) **Financial Requirements.** The applicant must meet income and resource standards for EAD eligibility based on the SSI methodology –

- Income. Total countable income must be at or below 100% of the FPL for an individual or couple; and
- Resources. Total available resources must not exceed \$4,000 for an individual/\$6,000 for a couple.

(c) **Determination Process.** RI Bridges evaluates all persons who self-report a disability who are over 19 for EAD coverage, even if they are determined eligible under the MACC group pathway. As indicated below, the EAD eligibility process evaluates whether a person qualifies under one of the SSI-related groups on the basis of special disregards and/or the Medicare Premium Payment Program (MPPP) before considering more specialized forms of Medicaid coverage such as the Sherlock Plan or Medically Needy. Federal regulations at 42 CFR 435.404 require EOHHS to provide anyone determined eligible for multiple forms of Medicaid to choose the coverage group that best suits their needs.

(d) **Continuing Eligibility.** With implementation of RI Bridges, EOHHS is instituting a passive renewal process. Beneficiaries are required to review and update a pre-populated form containing information maintained in RI Bridges about eligibility factors subject to change, such as income and resources that may affect continuing access to coverage. Detailed provisions pertaining to the passive renewal process are set forth in Section 1403.

(e) **Agency Responsibilities.** The EOHHS or its designated eligibility agent is responsible for evaluating applications for EAD eligibility, enrollment, and processing renewals. In addition, prior to ending EAD health coverage, the EAD must conduct a review to determine whether eligibility exists through any other eligibility pathway. Other responsibilities are set forth in greater detail, as appropriate and indicated, in other

sections of this rule.

### **E. Medically Needy (MN) Eligibility Pathway**

Medically needy coverage is available to certain IHCC group members who do not need LTSS. Different rules apply for LTSS medically needy eligibility as indicated in MCAR, Chapter 1500. 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 MNIL for the EAD income limit, but otherwise meet all of the requirements EAD health coverage. Eligibility for members of this group is contingent upon spending excess income for Medicaid covered health services until the Medically Needy Income Limit (MNIL) is reached. The MN coverage group does not provide categorical eligibility for Medicaid. Under the RI Medicaid State Plan, MN coverage is an option for elders and adults with disabilities, children and pregnant women. Parents/caretakers and adults 19-64 in the MACC groups do not qualify for MN coverage, though they may seek MN eligibility by applying through the EAD pathway. A beneficiary's eligibility is contingent on health care expenses and, as such, is fixed for at six (6) month increments.

- (1) **Eligibility Criteria** – To qualify, a beneficiary must be otherwise eligible for EAD and have high health costs covered by Medicaid under the state plan or waiver for members of the IHCC groups. Obtaining Medicaid eligibility requires that all excess income above the EAD limit be spent on these until the MNIL is reached. Under the RI Medicaid State Plan, MN coverage is an option for elders and adults with disabilities, children and pregnant women. Parents/caretakers and adults 19-64 in the MACC groups do not qualify for MN coverage, though they may seek MN eligibility by applying through the EAD pathway. Proof of health expenses is required.
- (2) **Determination process** – RI Bridges automatically evaluates applicants who do not qualify for Medicaid in the other IHCC groups for MN coverage. Members of the MACC groups must contact an agency eligibility specialist if seeing MN coverage. Flexible test cases are determined for a six (6) month period beginning with the first day of the month in which the application is received. Eligibility as MN is not established, however, until the applicant has presented proof of medical expenses incurred or that remain outstanding for the eligibility period. Any medical expenses for which a beneficiary continues to be liable dating back to the retroactive period are also considered.
- (3) **Continuing eligibility** – The date of eligibility is the actual day of the month on which the applicant incurs a medical expense – not the billing date – which reduces income to the income standard. 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.
- (4) **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.
- (5) **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 EOHHS.

Specific provisions related to application of the medically needy flexible test of income are located in Section 1415.

## **F. SSI Recipients and SSI-related Groups with Protected Status**

Federal law requires the states to provide Medicaid health coverage to all recipients of SSI and SSP cash assistance. Medicaid beneficiaries who lose SSI may qualify for Medicaid through the eligibility pathways for SSI-related IHCC groups. Beneficiaries eligible for Medicaid in these groups are afforded protected status either through the application of special disregards or deemed eligibility in which they are treated as SSI recipients for Medicaid health coverage purposes.

This section establishes the Medicaid SSI and SSI-related coverage groups and, to the extent applicable, sets forth the relevant eligibility criteria, how they are applied, continuing eligibility criteria and the respective responsibilities of the agencies involved for determining eligibility. *In instances in which eligibility is determined by EOHHS, the EAD income and resource limits apply unless otherwise specified.*

- (1) **SSI Recipients** – There is no distinct State-based eligibility pathway for SSI recipients. Medicaid eligibility is automatic. The SSA determines eligibility for SSI. The State receives notification of the SSI recipient’s eligibility from the SSA and is responsible for enrollment unless or until the SSI recipient loses eligibility due to a change in income or disability status. The EOHHS is responsible for determining whether EAD coverage is available for SSI recipients who lose cash assistance through an alternative SSI-group pathway. In addition to current SSI cash assistance recipients, this coverage also includes:
  - SSI recipient pending a final determination of blindness or disability; and
  - SSI recipient under an agreement with the SSA to dispose of resources that exceed the SSI dollar limits on resources (recoupment).
- (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 the applicable characteristic while residing in one of several pre-approved SSP living arrangements as specified in R.I.G.L. 40-6-27.2.
  - (b) Determination process. The SSA determines eligibility for SSP for SSI recipients. As the State agency that shares responsibility with the SSA for administering the SSI program in Rhode Island, the Rhode Island Department of Human Services (DHS)

requires non-SSI recipients to qualify for SSP on the basis of the EAD or applicable LTSS eligibility criteria. Program requirements related to LTSS beneficiaries eligible for SSP are located in Chapter 1500 Eligibility criteria for all other SSP categories are located in the DHS Code of Administrative Rules in the section entitled: *Supplemental Security Income (SSI) and State Supplemental Payment Program* and are available on the RI Secretary of State's website at:

<http://sos.ri.gov/documents/archives/regdocs/released/pdf/DHS/8080.pdf>.

- (c) Continuing eligibility. Renewal of Medicaid for SSP recipients is conducted in accordance with the requirements for SSI or EAD, depending on the basis of eligibility, and the applicable requirements related to living arrangement. The amount of the payment, which depends on 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 RI Bridges. 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.
  - (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,” Medicaid eligibility has been protected for certain persons who receive Social Security or Retirement, Survivor, or Disability Insurance (RSDI) benefits and lose SSI/SSP payments, or would be eligible for such payments, were it not for annual cost of living adjustments (COLAs) which increased their income. The Pickle Amendment requires the State to disregard these COLAs, when determining EAD eligibility. Applying the disregard, using a specific federal formula, essentially deems the person an SSI recipient for Medicaid eligibility purposes.
- (a) Eligibility Criteria. Pickle Amendment coverage is available in this coverage group for a person who meets all other SSI eligibility criteria and:
    - Received or was entitled to receive both RSDI and SSI in some month after 1977;
    - Retains current eligibility for and is receiving RSDI;
    - Is currently ineligible for SSI; and
    - Receives income which would qualify the person for SSI after deducting all RSDI cost of living adjustments (COLA) since the last month in which there was

concurrent eligibility or both RSDI and SSI.

- (b) **Determination Process.** When determining Pickle eligibility, the current SSI federal benefit rate plus any SSP payment is compared to the beneficiary'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 eligibility criteria related to age and/or disability and resources 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 countable income amount at the time SSI eligibility ceased. At this point, the State discontinues Pickle Amendment eligibility and determines whether other coverage group eligibility is available.
- (d) **Agency Responsibilities.** SSA informs the State annually about potential members of this group 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, RI Bridges also evaluates whether Medicaid is available in any other coverage group.
- (e) **Applicant/beneficiary Responsibilities.** Potential members of this coverage group must provide any additional information that may be required to determine eligibility and comply with the applicable general requirements for SSI-based eligibility set forth in Section 1402.
- (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** – Working persons with disabilities who have excess income and meet the requirements to continue to receive SSI cash assistance are eligible for continued Medicaid coverage under Section 1619 (a) of the Social Security Act when the following criteria are met:

- (a) **Eligibility Criteria.** The person receiving SSI based on disability must have gross earnings at or above the SSI income standard and:
- Maintain disability status while working;

- Meet all other SSI eligibility criteria;
  - Was 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 criteria for 1619 (a), no Medicaid 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.
- (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 are eligible for other Medicaid coverage groups.
- (5) **Medicaid While Working** – Section 1619 (b) of the Social Security Act provides Medicaid to employed persons who no longer qualify for Section 1916 (a), *but need coverage to continue working*. This coverage group preserves Medicaid eligibility for adults who are blind or living with disabilities who lose SSI and/or the optional State Supplement Payment (SSP) due to increased income from employment alone or in combination with other countable income. Unlike Section 1619 (a) coverage, Section 1619(b) provides Medicaid While Working protection when SSI cash assistance is no longer available and only for the person in a couple who is working. A non-working SSI eligible spouse has no protection under 1619(b) and loses Medicaid when the earned income of his or her SSI spouse results in ineligibility.
- (a) Eligibility Criteria. The Medicaid While Working coverage group protects Medicaid for a person who received an SSI cash payment based on disability for at least one month in the most recent benefit period and –
- Continue to meet the disability criteria related to substantial gainful activity;
  - Not have sufficient 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
  - Need Medicaid coverage to continue to work or obtain employment.
- (b) Determination process. As long as the beneficiary meets the eligibility criteria for Medicaid While Working, no Medicaid 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.
- (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 are eligible for other Medicaid coverage groups.

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

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

- Were it not for RSDI benefit, the beneficiary would continue to be eligible for SSI and/or SSP;
- Received an SSI/SSP payment the month before RSDI payments began; and
- Is 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/SSP 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 in this coverage group. Notification is also provided to the State of the date in which Medicare Part A becomes available. The EOHHS 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 beneficiary is being evaluated for these other forms of coverage.

(7) **Adult Child with Disabilities** – Section 1634 of the Social Security Act provides protection of Medicaid eligibility status for certain adult children with disabilities who lose SSI due to excess income from a parent's RSDI benefits. 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 benefit is disregarded to preserve continuing Medicaid eligibility.

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

- At least eighteen (18) years of age;

- Living with a disabling impairment that began prior to the age of twenty-two (22) and meet the requirement;
  - An SSI recipient based on blindness or that disability; and
  - No longer qualify for SSI due to excess income resulting only from RSDI benefits associated with the retirement, death or disability of a parent.
- (b) Determination process. The EOHHS disregards the RSDI benefit paid to the adult child when calculating countable income for EAD eligibility. SSI rules for the treatment of income otherwise apply. Protected eligibility is grant if the RSDI benefit is the ONLY source of excess income.
- (c) Continuing eligibility. Protected status as a result of the RSDI 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 RSDI benefit disregard in this coverage group. 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 who lose SSI and/or SSP due to receipt of the RSDI Disabled Widow Benefits (DWB). For Medicaid purposes, these individuals 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 and be 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.

## **Section 1402.02. The Medicare Premium Payment Program (MPPP)**

### **A. Overview**

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. Medicare Part A is hospital insurance coverage and Medicare Part B is for physician services, durable medical equipment and outpatient services. 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. Dual eligible beneficiaries who qualify for the MPPP, but not full Medicaid coverage are referred to as "partial dual-eligibles"; those beneficiaries who meet the eligibility requirements for an IHCC or MACC group and qualify for Medicare are known as "full-dual eligibles."

Medicaid wraps around Medicare's coverage by providing financial assistance to dual-eligible 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 coverage, as described later in this section.

### **B. MPPP Coverage Groups**

Different types of dual-eligible beneficiaries receive different levels of Medicaid coverage. Under the MPPP eligibility pathways, all dual-eligible beneficiaries qualify for assistance with payment of Medicare premiums only or with Medicare premiums and cost sharing. Only full-dual eligible receive Medicaid coverage as well. For all dual-eligible MPPP coverage groups, the following apply unless otherwise specified:

- Determination process. Eligibility begins on the first day of the month in which the application is filed and all eligibility requirements are met; Cost-of-living increases in RSDI benefits (COLAs), effective in January each year are disregarded in determining income eligibility through the month following the month in which the annual FPL Guidelines update is published.
- Continuing eligibility. Eligibility is granted for a twelve (12) month period; and
- Retroactive coverage is available.

Each MPPP coverage group is listed below along with relevant information about eligibility

- (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 income of 100% of FPL or less and resources that do not exceed the amounts set annually by the federal government (see subsection (E) below). For eligible QMBs, 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 the Medicare Program does not exceed the amount Medicaid allows for the service. To qualify for Part A coverage, a person must have a work history of 40 quarters. The State purchases Part A for any QMB who is not but could be enrolled.
  
- (2) **QMBs with full Medicaid (QMB Plus)** – These individuals are entitled to Medicare Part A, have income of 100% FPL or less and resources at the SSI level – \$4,000 individual/\$6,000 couple, and are eligible for full Medicaid benefits. Also Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, Medicare deductibles and coinsurance. Includes Medically Needy Medicaid beneficiaries. EAD rules govern access to Medicaid retroactive coverage, continuing eligibility and scope of coverage. MPPP rules apply to Medicare cost coverage.
  
- (2) **Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only)** – These individuals are entitled to Medicare Part A, have incomes of greater than 100% FPL, but less than 120% FPL, and resources, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.
  - Medicaid pays Medicare Part B premium to SSA;
  - Retroactive coverage is available.
  
- (3) **SLMBs with full Medicaid (SLMB Plus)** – These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL, and resources of \$4,000 individual/\$6,000 couple and are eligible for full Medicaid benefits. Medicaid pays the beneficiary's Medicare Part B premiums, coinsurance, deductibles and copayments, and provides full Medicaid benefits. Includes IHCC group members who qualify for Medicaid as “Medically Needy.”
  - Medicaid reimburses the SSA;
  - EAD rules govern access to Medicaid retroactive coverage, continuing eligibility and scope of coverage. MPPP rules apply to Medicare cost coverage.
  
- (4) **Qualified Disabled and Working Individuals (QDWIs)** – This group covers beneficiaries who lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less, and resources that do not exceed twice the limit for SSI eligibility (EAD limits of \$4,000

individual/\$6,000 couple), and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

- Medicaid makes a direct payment to the SSA for Part A premium. An individual cannot be reimbursed directly by Medicaid;
- 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.

(5) **Qualifying Individuals (1) (QI-1s)** – There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, have income of at least 120% FPL, but less than 135% FPL, resources that do not exceed the amounts set by the federal government (see subsection (E) below), and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. Federal matching funds for members of this group is 100%. For members of this group:

- Medicaid makes a direct payment to the SSA for Part B premium. An individual cannot be reimbursed directly by Medicaid;
- Eligibility begins the month in which the application is filed and ends on the last day of the year in which that month falls.

There are also dual-eligible beneficiaries who do not qualify for the MPPP under any of these coverage groups. Typically, these are Medicare beneficiaries receiving Medicaid coverage through the medically needy group for Community Medicaid. Medicaid coverage is available, but only to the extent that the Medicaid payment rate exceeds any Medicare payment for the service covered by both Medicare and Medicaid.

### **C. Medicare Part D**

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), established the Medicare Prescription Drug Program, also known as Medicare Part D, making prescription drug coverage available to Medicare beneficiaries. The new program went into effect on January 1, 2006. The MMA also provides for extra help (a subsidy) with prescription drug costs for eligible individuals whose income and resources are limited. This help takes the form of subsidies paid by the Federal government to the drug plan in which the Medicare beneficiary enrolls. The subsidy provides assistance with the premium, deductible and co-payments of the program. Beneficiaries may apply for the Low-Income Subsidy (LIS) with the SSA or with their State Medicaid agency.

(1) **Deemed Beneficiaries** – Certain groups of Medicare beneficiaries automatically qualify for the low-income subsidy and do not have to apply. These groups are deemed eligible for the subsidy from the first month of deemed status until the end of the calendar year. The federal Centers for Medicare and Medicaid Services (CMS) automatically awards deemed beneficiaries the subsidy based on information received from the states and SSA and

notifies them that they are eligible without having to file an application. They do, however, need to choose a prescription drug plan. Members of the following groups are deemed eligible:

- (a) Full-benefit Medicaid and Medicare dual eligibles that is, persons eligible for both Medicare and full Medicaid benefits;
  - (b) Supplemental Security Income (SSI) recipients, including SSI recipients who do not qualify for Medicaid, and persons with deemed or protected SSI status; and
  - (c) Medicare beneficiaries who are participants in the MPPP – QMB, QMB +, SLMB, SLMB +, and QI.
- (2) **Persons Not-Deemed Eligible** – Anyone who has not been deemed eligible for the LIS who has Medicare may apply through the SSA.
  - (3) **Eligibility Criteria for LIS** – An applicant must qualify for Medicare Part D – entitled to Medicare Part A and/or enrolled in Medicare Part B – and qualify for the MPPP or have income and resources within EAD limits.
  - (4) **Continuing Eligibility** – The SSA renews LIS benefits on an annual basis for beneficiaries who do not have deemed status.
  - (5) **Agency Responsibilities** – The SSA notifies the beneficiary and the State of LIS eligibility.
  - (6) **Applicant Responsibilities** – Once deemed or determined eligible, the LIS beneficiary is responsible for informing providers of enrollment in a Part D plan. Medicaid provides wraparound coverage for any prescriptions not included in the Part D plan as well as copays.

#### **D. MPPP Application Process**

There are multiple application pathways for pursuing MPPP eligibility.

- (1) **MPPP and RI Bridges** – Persons seeking MPPP coverage may apply through RI Bridges or the SSA. If applying through RI Bridges, a person has the option of applying for the MPPP only or full Medicaid coverage and the MPPP. Full details of these options are in MCAR, Section 1425.
- (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.

#### **E. MPPP Summary**

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

<b>MPPP Eligibility Pathways – 2016</b>			
<b>Coverage Group</b>	<b>Full or Partial Eligible</b>	<b>Income and Resource Limits Individual/Couple</b>	<b>Benefits</b>
<b>QMB</b>	Partial Dual	100% FPL + \$20 \$7,280/\$10,930	Entitled to Medicare Part A, only eligible for Medicaid under MPPP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> <li>♣ Medicare Part A premiums (if needed)</li> <li>♣ Medicare Part B premiums</li> <li>♣ Certain premiums charged by Medicare Advantage plans</li> <li>♣ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program)</li> </ul>
<b>QMB +</b>	Full Dual	100% FPL + \$20  \$4,000 / \$6,000	All of the Above AND full Medicaid coverage
<b>SLMB</b>	Partial Dual	101-125% FPL + \$20 \$7,280/\$10,930	Entitled to Medicare Part A, only eligible for Medicaid under MPPP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> <li>♣ Medicare Part B premiums</li> </ul>
<b>SLMB +</b>	Full Dual	101-120% FPL + \$20  \$4,000 / \$6,000	Same as Above AND: <ul style="list-style-type: none"> <li>♣ Certain premiums charged by Medicare Advantage plans</li> <li>♣ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program)</li> <li>♣ Full Medicaid Coverage</li> </ul>
<b>QI</b>	Partial Dual	121-135% FPL + \$20	Entitled to Medicare Part A, only eligible for Medicaid under MPPP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> <li>♣ Medicare Part B premiums</li> </ul>
<b>QWDI</b>	Partial Dual	200% FPL \$7,280/\$10,930	Lost Medicare Part A benefits because of return to work but eligible to purchase Medicare Part A, only eligible for Medicaid under MPPP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> <li>♣ Medicare Part A premiums</li> </ul>

MPPP Eligibility Pathways – 2016			
Coverage Group	Full or Partial Eligible	Income and Resource Limits Individual/Couple	Benefits
<b>Alternative Eligibility Pathway for Dual Eligible Beneficiaries with Higher Income</b>			
Coverage Group	Full or Partial Eligible	Income and Resource Limits	Benefits
Not Eligible for MPPP	Full Dual	Income at or below 300% of the SSI benefit rate \$2,000 / \$3,000	Medically Needy, usually LTSS, not eligible for MPPP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> <li>♣ Certain premiums charged by Medicare Advantage plans</li> <li>♣ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid</li> <li>♣ Full Medicaid Coverage</li> </ul>

**Section 1402.03. Special Coverage Groups**

**A. Overview**

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

**B. Breast and Cervical Cancer**

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 in this coverage group.

- (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 and found to need treatment for either breast or cervical cancer, or a precancerous condition of the breast or cervix. In addition, an applicant must not be Medicaid eligible in another coverage group or have access to or be enrolled in a health insurance plan that provides essential benefits, as defined in federal regulations at 42 CFR 447.56 All general requirements for Medicaid must also be met.
  
- (2) **Determination process** – Members of this coverage group are not required to meet EAD income and resource limits or those established for other Medicaid coverage groups. 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:
- Attains age sixty-five (65);
  - Acquires qualified health insurance/creditable coverage;
  - No longer requires treatment for breast or cervical cancer;
  - Fails to complete a scheduled redetermination;
  - Is no longer a RI resident;
  - 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 to EOHHS about the status of their condition/treatment prior to the date of redetermination or at intervals specified.

### C. Refugee Medicaid

Refugee Medicaid or Medical Assistance is a 100% 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. The Medically Needy option is only available to refugees who are otherwise ineligible for Medicaid coverage under Chapter 1300, using the MAGI methodology, EAD under this Chapter, or subsidized health insurance through HealthSource RI.

- (1) **Eligibility Criteria** – Any member of federal resettlement program for refugees who has income above the applicable Medicaid coverage group limit or is disqualified from Medicaid or a commercial plan through Healthsource RI on the basis of age or income, may apply for Medically Needy eligibility if he or she has high health care expenses. The criteria set forth in Section 1415 apply 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. If determined eligible in one of the MACC groups, the beneficiary is enrolled in a managed care plan for the duration of the period of

eligibility. For refugee beneficiaries who qualify for Medicaid as Medically Needy, services are provided on a fee-for-service basis.

- (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% federal matching funds continue until the end of the eight month or the date in which the person no longer meets the immigration status requirement, whichever comes first. Prior to ending eligibility for Medicaid in this coverage group, 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 once the eight month period ends and requires states to continue Medicaid eligibility under any other coverage group for which a refugee may qualify for a minimum of seven (7) years, providing all other requirements are met. Renewals for continuing coverage of conducted in accordance with the applicable coverage group requirements.
- (4) **Agency Responsibilities** – Beneficiaries eligible under this section are require to meet the spenddown requirements set forth in Section 1415. 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 MACC group eligibility
- (5) **Applicant responsibilities** – Beneficiaries are responsible meeting the spenddown requirements set forth Section 1415.

#### **D. 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 USC section 1396a(a)(10)(ii)(XIII)). People eligible under this category are entitled to the full scope of Medicaid benefits, home and community-based services, and services needed to facilitate and/or maintain employment. Participants may be required to pay a premium in order to remain active on the program.

In general, to be eligible for the Sherlock Plan, a person must meet the following requirements:

- At least eighteen (18) years of age and qualify for EAD Community Medicaid based on disability, excluding the substantial gainful employment provision, or the LTSS Medicaid functional disability criteria set forth in Chapter 1500;
- Active, paid employment and countable earned net income no greater than 250% of the FPL. Countable income is defined as the total earned income remaining after all SSI-related

disregards are applied; and

- Countable assets no greater than \$10,000 (individual) or \$20,000 (couple).

Full details of the Sherlock Program requirements are located in MCAR, Section 1373.

## **E. Emergency Medicaid**

Medicaid health coverage is available to non-citizens in emergency situations who meet all the general and income requirements for a specific group with the exception of immigration status. Coverage is for the emergency period only and does not include any follow-up services that are deemed medically necessary to prevent the need for emergency services for the same illness, disease or condition in an acute care facility.

## **Section 1402.04. Preventive Level Services**

### **A. Scope and Authority**

Under the terms of the State's Section 1115 demonstration waiver, beneficiaries who do not yet need Medicaid LTSS but are at risk for the NF level of care have access to services targeted at preventing admission, re-admissions or reducing lengths of stay in a skilled nursing facility. Beneficiaries who meet the needs-based criteria for the preventive a level of care are eligible for a limited range of home and community-based services and supports along with the full range of non-LTSS state plan and waiver health care benefits they are entitled to receive. Preventive care services optimize and promote beneficiary health, safety and independence through an array of care interventions that alleviate or minimize symptoms and functional limitations. Accordingly, the goal of preventive services is to delay or avert institutionalization or more extensive and intensive home and community-based care.

### **B. Scope of Services**

Depending on a beneficiary's needs, the following preventive level 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. These services may be available when an eligible person can no longer do these tasks on their own and has no other person available to help them. Limited personal care may also be available.
  - 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. They 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.

### C. Clinical Evaluation

To qualify, the Office of Medicaid Review (OMR) must determine that one or more 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)<sup>1</sup> and/or delay or mitigate the need for intensive home and community-based or institutionally based care. Detailed information about the clinical evaluation process is provided in MCAR, Section 1501.01.

### D. 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.

### E. Continuing Need

The need for preventive services is reassessed annually in conjunction with the renewal process. Preventive services continue until the beneficiary or provider who referred the beneficiary for preventive services indicates 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 terminate. Beneficiaries are notified of the date of a clinical evaluation at least ninety (90) days in advance.

### Section 1402.05 Summary – Financial Eligibility: IHCC Community Medicaid

The income limit is the ceiling set for income eligibility for an IHCC group based on the FPL, which are adjusted annually, or alternative measure of need established in federal or State law. For most IHCC groups, the income limit is set for an individual or a couple rather than for family size and considers income and resources of other members of an applicant’s household only to the extent that “deeming” rules apply.

Income limits are updated annually, and eligibility systems are adjusted accordingly no more than thirty (30) days after the FPL guidelines are released each year by the federal government. The following are the income limits for IHCC groups in this section:

<b>IHCC Financial Eligibility Standards Community Medicaid</b>		
<b>Coverage Group</b>	<b>Income Limit</b>	<b>Resource Limits Individual/Couple</b>
EAD	100% of FPL	\$4,000/\$6,000
Medically Needy	Medically Needy Income Limit – Varies Annual	\$4,000/\$6,000
SSI	75% FPL	\$2,000/\$3,000

<sup>1</sup> IADLs is an acronym that refers to skills required for independent living that include: using the telephone, traveling, shopping, preparing meals, doing housework, taking medications properly, and managing money.

<b>IHCC Financial Eligibility Standards Community Medicaid</b>		
<b>Coverage Group</b>	<b>Income Limit</b>	<b>Resource Limits Individual/Couple</b>
SSP	100% FPL	SSA – \$2,000/\$3,000 EOHHS -\$4,000/\$6,000
SSI-Related Groups	100% FPL	\$4,000/\$6,000
MPPP*		
• QMB	100% FPL	\$7,280/\$10,930
• QMB +	100% FPL	\$4,000 / \$6,000
• SLMB	120% FPL	\$7,280/\$10,930
• SLMB+	120% FPL	\$4,000 / \$6,000
• QI	121 – 135% FPL	\$7,280/\$10,930
• QWDI	200% FPL	\$7,280/\$10,930
Sherlock Plan	250% FPL	
Breast and Cervical Cancer Treatment	250% FPL – DOH limit	None
Refugee Medicaid	Medically Needy when above MAGI – 133% FPL	None
Emergency Medicaid	Varies by Coverage Group	None

\*All MPPP income is also subject to a \$20 additional disregard.

## **Section 1403. Application Process for IHCC Groups**

### **A. Overview**

The ACA provided the states with the opportunity to obtain matching funds to offset the costs of building health care eligibility engines with the capacity to evaluate applicants for both Medicaid and commercial coverage available through a single health insurance marketplace. Rhode Island pursued this option and, in 2014, launched HealthSource RI to determine eligibility for health coverage paid for in whole or in part through Medicaid, federal and/state financial help (subsidies, advanced premium tax credits and cost-sharing reductions). The State also took advantage of other available sources of federal funding to replace its legacy health and human services eligibility system known as InRhodes. In July 2016, the State implemented a new, highly sophisticated integrated eligibility system – called “RI Bridges” – which has the capacity to cross-walk with HealthSource RI and, through a single application process, evaluate eligibility for publicly-financed health coverage and needs-based programs administered by DHS and other EOHHS agencies.

### **B. Scope and Purpose**

All persons seeking publicly-financed health coverage and human services may apply through the RI Bridges system. This includes Rhode Islanders seeking Medicaid, RI Works, SNAP, Child Care Assistance, and the SSP, among other programs. The system has two user-friendly consumer portals for applicants, as well as an agency portal for general eligibility and LTSS specialists to assist Rhode Islanders seeking health coverage and/or assistance in completing the application

process. Access to the consumer on-line self-portals is available at: [www.HealthSourceRI.com](http://www.HealthSourceRI.com) and [www.dhs.ri.gov](http://www.dhs.ri.gov) Paper applications are also available and may be submitted in-person or through the U.S. mail. Persons seeking health coverage also have the option of making application by telephone.

### **C. Application Access Points**

The State is committed to pursuing a “No Wrong Door” policy that offers consumers multiple application access points which all lead to the RI Bridges integrated eligibility system.

- (1) **RI Bridges Consumer Self-Service 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](http://eohhs.ri.gov)) and DHS ([dhs.ri.gov](http://dhs.ri.gov)) websites or directly through HSRI ([HealthSourceRI.com](http://HealthSourceRI.com)). There are also kiosks located in DHS field offices that provide direct access to the on-line 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 on-line option and complete and submit the application electronically whenever feasible. NOTE: Applicants using the on-line system will have to establish their identity electronically to create an account. If an identity match cannot be completed on-line, documentation may be provided via upload, fax, mail, or in-person.
- (2) **In-person or On-paper** – 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. Agency representative are available to assist applicants in completing paper application or applying on-line in person in DHS field offices.

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 or in-person at any DHS field office. Information provided on the paper application directly into the eligibility system portal and submit the application for a determination on the applicant’s behalf.

### **D. Completing and Submitting the Application**

RI Bridges has a user-friendly consumer portal for applicants as well as an agency portal for general eligibility and LTSS specialists to assist Rhode Islanders seeking health coverage and/or assistance in completing the application process. 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 or agency representative assisting the applicant must create a login and establish an account in the eligibility system.

- (a) Identity proofing. The applicant must provide personally identifiable information for the purpose of creating an on-line account as a form of identify proof during this process. 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, the RI Bridges conducts account matches to determine whether the applicant or members of the applicant's household have other accounts or are currently receiving benefits.
- (2) **Account Duration** – An application account is open for a period of ninety (90) days. Applications may be started at any time. Once started, progress can be saved at any point and the application returned to at a later time. Incomplete applications not submitted within ninety (90) days are automatically deleted in the eligibility system.
- (3) **Application Materials** – The application materials a person seeking Medicaid coverage must have on hand may vary depending on the application processing flow:
- (a) MAGI-based eligibility. As indicated in Section 1403.03, 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 using the SSI methodology's more comprehensive financial standards. The MACC group, MAGI-based application process is explained in greater detail in MCAR, Section 1303.04. The MACC group 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 in 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.
- (01) Materials that may be of assistance in completing the application include, but are not limited to:
- Federal tax filing status
  - Social Security Numbers
  - Birth Dates
  - Passport or other immigration numbers
  - Federal tax returns
  - Information about any health coverage available to you or your family,

including any information you have about the health insurance your current employer offers even if you are not covered by your employer's insurance plan, Medicare and other forms of coverage

- W-2 forms with salary and wage information if you work for an employer
- 1099 forms, if you are self-employed

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

- Copies of checks or receipts for unearned or irregular income
- Bank statements
- Annuity/retirement fund statements for insurance companies
- Copies of bonds.
- Stock ownership statements.
- Copies of life insurance policies.
- Statements from insurance companies or companies providing annuities.
- Copies of burial purchase agreements

(03) Common documents that may be required with respect to Self-Employment Income include:

- Tax forms such 1040 Schedule ES (Form 1040), Schedule C or comparable State form or federal return with the "Self-Employment Tax" line completed.
- Business records if the applicant has not been self-employed long enough to file taxes, including – financial statements, gross receipts and expenses, quarterly reports, certified statement form licensed accountant.
- For royalties, honoraria, and stipends, the nature and amount of payments, any Social Security of Medicare withholding, dates of payments and frequency of payments, and/or tax forms above or 1099 MISC and the name of the issuer

(4) **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 RI Bridges when using the consumer self-service portal. In cases in which the agency representative is entering the information into the eligibility system on the applicant's behalf, information about necessary documentation must be made available as soon as feasible. Applicants have the option to submit any additional documentation or materials that may be required to complete the determination of eligibility through an on-line upload, by email, U.S. mail, fax, telephone or in-person.

(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 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.

- (6) **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 providing an electronic signature under penalty of perjury. RI Bridges verifies the information electronically to the fullest extent feasible and must verify applicant attestations in accordance with the procedures set forth MCAR, Sections 1303 and 1308.
- (7) **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 and its designated eligibility must maintain the privacy and confidentiality of all application information and in the manner required by applicable federal and state laws and regulations.
- (8) **Eligibility Determination Timelines** – Federal and state law set specific timelines for Medicaid determinations of eligibility. The EOHHS is responsible for processing applications and making determinations within these timelines for IHCC group members who have not been deemed or determined eligible on the basis of participation in another needs-based program (e.g., SSI, DCYF Foster Child, Refugee Medicaid, etc.). The timelines are as follows:

<b>MACC and IHCC Eligibility Determination Timelines</b>	
<b>Coverage Group</b>	<b>Determination Timeline</b>
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 of level of care is required – 90 days
Medically Needy – Persons with Disabilities	90 Days
Medically Needy – No Disability	30 Days
LTSS	90 Days

**E. Beneficiary Responsibilities**

Medicaid beneficiaries must ensure that the EOHHS has access to 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 affordable coverage 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 on-line 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 request must be made in writing and preferably two (2) weeks prior to the date of disenrollment. 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 EOHHS at the time of application and any annual renewals thereafter is accurate and truthful.

## **Section 1403.01 Application Review Process**

### **A. Overview**

The Medicaid program was originally designed to provide “medical assistance” to low-income people in certain, mutually exclusive categories of need – aged, disabled, pregnant, child, and cash assistance recipients. Although the Medicaid program and health care more generally have changed dramatically since the mid-1960s, elements of the “categorical” approach to eligibility remain with the program today, as is evident in this rule. One of the principal objectives of the ACA was to shift the focus in publicly-financed health care away from eligibility categories while still preserving access for those with the greatest need. Today, people who once applied for a category of Medicaid coverage apply, instead, for affordable coverage and are evaluated using the same income standard irrespective of who provides the coverage, the scope of benefits, or the source of funding.

Rhode Island is uniquely situated to take the ACA approach to eligibility and expand to include the eligibility categories subject to the SSI methodology for two reasons:

- **Broad and Uniform Benefits** – Medicaid beneficiaries in Rhode Island generally receive the same set of services irrespective of eligibility pathway within and across the IHCC and MACC groups, though there are necessary and appropriate differences in the scope of LTSS benefits. As a practical matter, this means that the least restrictive eligibility pathway(s) serve the interests of the majority of beneficiaries;
- **RI Bridges** – To some extent, federal regulations the states must follow perpetuate the categorical eligibility approach – i.e., multiple coverage groups, targeted at populations with particular characteristics, and heavy laden with both distinct and overlapping requirements. The State’s integrated eligibility system has the capacity and has been programmed to use applicant information to consider eligibility across these coverage categories, beginning with the most expansive and least restrictive (most often MAGI-based) and from there moving on to the more specialized and more limited (SSI-related). In short, RI Bridges uses the information applicants provide to determine eligibility for available categories of Medicaid health coverage rather than any single one.

As a result of these two factors, applicants using RI Bridges have the opportunity to be considered for multiple forms of health coverage through a single, streamlined eligibility determination and, often, on-line and in real time.

## **B. Scope and Purpose**

This section sets forth the process for evaluating applications and determining eligibility for Medicaid health coverage. The focus in this chapter is on the IHCC groups subject to the SSI methodology. However, most applicants will be considered for the MACC groups using the MAGI standard prior to an evaluation using the IHCC eligibility pathways.

The purpose of this multi-faceted approach to reviewing applications is to minimize the burden on applicants and maximize the opportunities for eligibility. The goal in this section is to explain in simple language the various ways that RI Bridges evaluates applicants in the IHCC groups.

## **C. RI Bridges Conversion Process**

The conversion from InRhodes to the RI Bridges requires new applicants and current beneficiaries to be treated as follows:

- (1) **New Applicants** – New applicants using RI Bridges are evaluated first using MAGI methodology for the MACC groups which do not have resource requirements. The following shows the MACC eligibility possibilities for someone with an IHCC group eligibility characteristic.
- (2) **Existing Beneficiaries** – At the time of renewal, current IHCC beneficiaries are evaluated using the SSI methodology to ensure continuity of coverage. In the process of this evaluation, RI Bridges considers whether, based on the information about income and

resources, MAGI-based eligibility in one of the MACC groups may be available. RI Bridges then determines eligibility using the MAGI rules and notifies the beneficiary if an alternative form of coverage is available.

#### **D. Eligibility Options**

**Across Coverage Categories.** Applicants between the ages of 19 and 64 who self-report a disability and are not requesting LTSS are evaluated for Medicaid Affordable Care Coverage (MACC) in the adult group using the MAGI eligibility standard as well as for IHCC eligibility based on the SSI methodology.

#### **E. General Rules**

When an applicant/beneficiary is determined eligible in one of the MACC groups, RI Bridges auto-authorizes coverage. RI Bridges provides the applicant/beneficiary with the *choice* to proceed to an SSI-based determination at that point unless required by limits or restrictions established in federal or State laws, regulations and/or requirements. When making such choices, the following apply:

- (1) **Limits** – Although the scope of benefits across Medicaid coverage groups is generally the same, 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 only available to IHCC group members.
  - (b) **Third-Party 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, who are have no other eligibility pathway.
  - (c) **Former SSI Recipients.** All former SSI recipients who lose cash assistance due to excess income must be evaluated first for the SSI-related protected/deemed status groups. In instances in which eligibility in one of these groups is unavailable, RI Bridges considers IHCC Community Medicaid options. A former SSI recipient who is no longer disabled and is found ineligible on this basis is generally ineligible for SSI-protected status and must be evaluated continuing coverage accordingly.
  - (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 are the only exceptions. Children and youth under 19 are generally not eligible in the IHCC group. However, children with high health care expenses who have family income above the MACC group limit may seek medically needy coverage using the SSI methodology. IHCC resource and deeming rules apply, unless the child is seeking LTSS through the Katie Beckett eligibility provision.

- (e) Preventive Level Services. These services are only available to adults with disabilities and elders eligible through the IHCC groups.
  - (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, irrespective of whether initial income eligibility is determined on the basis of MAGI or the SSI methodology.
  - (g) Medically Needy Eligibility. For all non-LTSS applicants, Medically Needy 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. For LTSS applicants, Medically Needy 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 through the IHCC groups.
- (2) **Impact of Limits** – Federal regulations preclude certain persons seeking initial or continuing eligibility from obtaining coverage in the MACC groups. The impact of these limitations are as follows:
- (a) Persons 65 and older. Elders are not eligible for MAGI-based MACC group coverage EXCEPT as a parent/caretaker relative of Medicaid eligible child. IHCC groups are thus the principal source of coverage for persons over 65.
  - (b) Adults with disabilities and persons who are blind (19-64). There is a higher income eligibility standard (MACC is 133% of the FPL v. EAD at 100% of the FPL) for MACC group coverage for adults in this age group and no resource limits or requirements for a disability determination.
    - Adults with disabilities who otherwise meet the applicable income guidelines (133% of the FPL with 5% disregard) are evaluated first for MAGI-based eligibility if the Medicare restriction does not apply.
    - MAGI eligible members of this group who choose to pursue Medicaid in an IHCC group – e.g., if seeking retroactive coverage – are auto-authorized for the applicable MACC group for adults and have the option of enrolling in a Medicaid health plan while awaiting a disability determination. SSI income and resource requirements apply when transitioning from a MACC to an IHCC group, however.
    - RI Bridges evaluates adults with disabilities who have income above the EAD

limit of 100% of the FPL and the MACC Adult group limit of 133% of the FPL for the Sherlock Plan if they report on the application that they have work-related earnings.

## **Section 1403.02 Renewal of Eligibility for IHCC Groups**

### **A. Overview**

One of the principal requirements of Medicaid health coverage groups is that continuing eligibility must be re-evaluated at least once year. For the IHCC groups this annual review was referred to as a “redetermination” and, accordingly, often required beneficiaries to essentially reapply for coverage. The federal Affordable Care Act (ACA) in 2010 reaffirmed the need for yearly reviews of continuing eligibility, but established clearly that the purpose was to renew health coverage rather than redetermine eligibility. Accordingly, current federal regulations (42 CFR 435.916(b) governing the IHCC groups – i.e., Medicaid coverage groups subject to the SSI methodology – now require that these annual reviews consider only those eligibility factors that are subject to change – income, resources, household size or residency, for example. State Medicaid agencies are also required to automate continuing eligibility reviews to the full extent feasible and to recast the process as eligibility renewal instead of redetermination or recertification. For Medicaid populations subject to the SSI methodology, Rhode Island’s IHCC groups, the states are required to use a “modified” active or passive renewal process that limits the burden on beneficiaries seeking continuing coverage.

### **B. Scope and Purpose**

With the implementation of RI Bridges, the State is instituting an automated modified active renewal process which reduces the scope of review and minimizes burden on beneficiaries in a manner that meets or exceeds federal requirements. The continuing eligibility for the IHCC group beneficiaries receiving Community and LTSS Medicaid is conducted using a modified active renewal process which requires beneficiaries to review information known to RI Bridges on key eligibility factors and report any inaccuracies or changes in the manner described in this section. Such factors include income, resources, household composition (e.g., as a result of births, deaths, divorce, etc.), disability or clinical factors, and/or access to third-party coverage 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.

The provisions in this Section do not apply to beneficiaries who are deemed eligible due to participation in other programs or that are determined eligible by the SSA. Special MPPP renewal provisions also apply.

### **C. EOHHS Responsibilities**

The EOHHS conducts IHCC group renewals 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 EOHHS 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 RI Bridges. The EOHHS does 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. 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** – The EOHHS must provide timely notice 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 RI Bridges 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, the EOHHS provides Medicaid beneficiaries 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.
- (4) **Consent** – At the time of initial application, Medicaid beneficiaries sign a consent form permitting the EOHHS to obtain and verify information through RI Bridges and external data sources and certain providers for the purposes determining eligibility and renewing health coverage. The first time IHCC group beneficiaries are renewed through RI Bridges, such consent must be provided if it does not already exist.
- (5) **Modified Active Renewal** – All IHCC beneficiaries are subject to a modified active renewal process, that proceeds as follows:
  - (a) **Initial Bridges Renewal.** During the first RI Bridges renewal, the EOHHS provides all IHCC beneficiaries with a pre-populated form containing all information related to eligibility known to RI Bridges. 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 RI Bridges 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.

#### **D. Beneficiary Responsibilities**

Medicaid beneficiaries must meet the requirements associated with making and completing an application as set forth in Section 1403 (E).

#### **Section 1404. General Eligibility Requirements**

##### **A. 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.

##### **B. Characteristic Requirements**

A person applying for Medicaid EAD eligibility coverage must establish their categorical relationship to SSI by qualifying on the basis of one of the following:

- (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.

**Verification:** An applicant’s age is verified electronically with information about date of birth from the U.S. Social Security Administration (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 clinical criteria for determining disability established by the MART, or the SSA for SSI cash assistance or SSDI. **Note:** An applicant must be determined disabled due to blindness by the MART or by an entity of the SSA. If income is at or below SSI income standard, a disability determination is NOT required.

##### **C. Non-Financial Criteria**

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 coverage are required to provide a SSN. 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 unavailable, other proof of income must be accepted.
- (b) **Limits on Use** – Applicants must also be informed that SSN will be utilized only in the administration of the Medicaid program, including for use 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** – An individual must be a resident of Rhode Island to meet the residence requirement. The state of residence of an individual 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 Rhode Island 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:

- (01) 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 individual is living.
- (02) Any person residing in a health care or treatment institution who is under the age of 21, or who is 21 or older and became incapable of indicating intent prior to the age of 21, the state of residence is that of –
- The parents or legal guardian, if one has been appointed, or
  - The parent applying for Medicaid on behalf of the individual if the parents live in different states, or
  - The person or party who has filed the application on behalf of the applicant if the applicant has been abandoned by his or her parents and does not have

a legal guardian.

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

- (01) If not living in an institution, the state of residences is the one in which the person is living –
  - With intent to remain permanently or for an indefinite period of time;
  - While incapable of stating intent; or
  - After entering with a job commitment or in pursuit of employment whether or not currently employed.
- (02) A person age 21 or older who is residing in an 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.
- (03) 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 there 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:

- Obtaining necessary health care;
- Visiting;
- Obtaining education or training under a program of the RI Office of Rehabilitation Services, Work Incentive or higher education program, or
- Residence in an LTSS facility in another state, if arranged by an agent of the State of Rhode Island, unless the individual or his/her parents or guardian, as applicable, state 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 an individual's placement in a Rhode Island institution, the individual remains a resident of the state which made the placement, irrespective of the individual's intent.
- (g) Incapable of Stating Intent. Persons are incapable of stating intent regarding residence if:
- They are judged legally incompetent;
  - Their IQ is 49 or lower, or they have a mental age of 7 or lower, based on tests acceptable to the Developmental Disabilities Division of the Rhode Island Department of Behavioral Healthcare, Development Disabilities, and Hospital; or
  - Medical documentation, or other documentation acceptable for disability determination purposes, supports a finding that they are incapable of stating intent.
- (h) Residence as Payment Requirement. An individual 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, a state may not deny Medicaid eligibility to an applicant for any of the following reasons:
- Failure to reside in the State for a specified period; or
  - 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
  - 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
  - Failure to have a permanent or fixed address. Homeless persons may designate a mailing address.

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

**(3) Living Arrangements** – A person's living arrangement is a factor when determining the FRU membership, SSP eligibility and payment amounts, and whether the Medicaid eligibility unit consists of an individual or couple. In addition, incarceration is also a factors that affects eligibility status and access to Medicaid coverage

- (a) IHCC 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:

- Living in own home such as a house, apartment, or mobile home or someone else's household. Affects formation of the FRU and thus deeming;
- 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;
- 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;
- 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 supplement to SSI is affected by the above in addition to the following where an applicant/beneficiary resides and the scope of Medicaid coverage:

- Reside in a hospital or nursing facility for the whole month and Medicaid pays for over one-half of the cost of care;
- Medicaid LTSS beneficiary living in either an appropriately certified residence/home participating in the Medicaid Community Supportive Living Program established under R.I.G.L. § 40-8.13-12, or Medicaid certified assisted living residence authorized in accordance with R.I.G. L. § 40-6-27;
- Medicaid beneficiary who is SSI or EAD eligible (non-LTSS) and is residing in an assisted living residence;
- 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
- 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.

**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 within ten (10) days of the date the change occurs for all applicants and beneficiaries.

- (c) **Correctional Facility.** While living in a correctional facility, including a juvenile facility, full Medicaid 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 incarceration begins until the date the person moves out of the correctional facility. An individual 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.

**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.

- (3) **Citizenship and Immigration Status** – An applicant for coverage in the 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. There are exceptions in federal law that permit qualified non-citizens with certain immigration statuses to obtain Medicaid coverage during the five-year bar.

“*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 temporary or 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 are not eligible for Medicaid in any IHCC group except in emergency situations. Non-emergency services may be obtained through Federally Qualified Community Health Centers.

Specific provisions related to citizenship and immigration are contained in MCAR, Section 0304.

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

- (4) **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) Assign to the State any rights they may have (or any other Medicaid eligible may have for whom they can legally assign rights) to support and payment for medical care from any responsible third party (e.g., from an insurance company settling an accident claim);
- (b) 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;
- (c) Agree to cooperate with the State in obtaining medical support and payments (e.g., signing papers necessary to pursue payments from absent parents);
- (d) Agree to apply for eligibility for any other forms of public assistances which may be applicable;
- (e) Enroll in a RIte Share-approved employer-sponsored health insurance plan if cost-effective to do so, in accordance with MCAR, Section 1312; and
- (f) Agree to cooperate in establishing the paternity of a child born out of wedlock for whom the applicant can legally assign rights.

**D. Good Cause for Failing to Cooperate**

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 individuals supporting the claim.

- 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.
- 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.

Upon making a final determination, notice must be sent to person making the claim. The notice must include the right to appeal through the EOHHS Administrative Fair Hearing Process set forth in MCAR, Section 0110.

**Section 1404.01 Disability Determinations**

**A. Scope and Purpose**

Disability determinations are made by Medicaid Assessment and Review Team (MART) in accordance with the applicable requirements of the Social Security Administration (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.

## **B. Disability Standards for Community Medicaid**

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 of chronic 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 individuals do less, get paid less or have less responsibility than when they worked before. 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 in this age group are made by the MART based on an assessment of whether the applicant is unable to engage in any substantial gainful activity because of any medically determinable physical or mental impairment, or combination of impairments, that can be expected to result in death, or has lasted or can be expected to last for a continuous period of not fewer than 12 months. To meet this definition, individuals must have a severe impairment, which makes them unable to do their previous work or any other substantial gainful activity which exists in the national economy. To determine whether individuals are able to do any other work, the MART considers their residual functional capacity, age, education, and work experience.
  - (b) Children under age 19 – Medically Needy Only. The MART is not usually responsible for making disability determinations for persons under 19. In general, such determinations are made formally by 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, that can be expected to result in death or that have lasted or can be expected to last for at least 12 consecutive months. The MART may make such disability determinations for medically needy applicants under age 19 using the criteria for applying this standard in the absence of a determination by another qualified entity.

- (c) Disability based on Blindness. Applicant seeking eligibility for a disability based on blindness who do not qualify for SSI due to excess income 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 only applies if the applicant otherwise meets the requirements set forth for coverage under the Sherlock Plan in Section 1373.

### **C. Eligibility Determination Sequence and Referral to the MART**

All adults over age nineteen (19) applying for Medicaid are evaluated by RI Bridges 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 months prior to making application.

- (1) **Referral to the MART** – Applicants who indicate that they have been determined disabled by a government agency or are seeking retroactive eligibility are referred to the MART for a disability review if they:
  - Do not qualify for MAGI-based coverage due to Medicare eligibility or enrollment or an official determination of disability by a government agency and/or seek retroactive eligibility; or
  - Qualify for such MAGI coverage but would prefer to be evaluated for IHCC through a pathway for Community Medicaid.
- (2) **Limits on Referral** –The MART may only make a disability determination if the applicant:
  - (a) Has not applied for SSI or applied for SSI and was found ineligible for a reason other than disability.
  - (b) Applied for SSI and SSA and has not made a disability determination within 90 days from the date of the application for Medicaid.
  - (c) Has been found “not disabled” by SSA, has filed a timely appeal with SSA, and a final determination has not been made by SSA.
  - (d) Experienced a change or deterioration in a chronic illness or potentially disabling condition since the most recent SSA determination of “not disabled”, all disability duration requirements of the SSA have been met (i.e., condition expected to last, AND:
    - The SSA determination was made more than 12 months ago and the applicant has not sought a new SSA determination on this basis; OR

- The SSA determination was fewer than 12 months ago, the disability meets the durational requirements of the Act and the applicant applied to SSA for reconsideration or reopening of its disability decision and SSA refused to reconsider the determination on this basis.

## **D. Agency and Applicant Responsibilities**

Applicant must provide the health care authorizations and information necessary to make a timely and accurate determination of disability. The MART is responsible for assuring that determinations are made in accordance with the federal Medicaid regulations at 42 CFR 435.541 and the disability criteria established by the SSA. The criteria used by the MART are located at [www.eohhs.ri.gov/](http://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, 6<sup>th</sup> Floor, Providence, RI 02903 or 1-877-402-0808 (TTY 401-273-6648).

### **Section 1404.03 Formation of Financial and Eligibility Groups**

#### **A. 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 financial responsibility unit (FRU) and the income limits applicable to the Medicaid eligibility IHCC group. For IHCC Community Medicaid, the income limit is the actual federal poverty limit – one hundred (100) percent of the FPL – adjusted for family size (individual or couple). One of the first steps in determining eligibility is thus to identify who is included in both groups. The purpose of this section is to establish the process for forming the FRU and the eligibility and the role it plays in determining eligibility for IHCC Medicaid.

#### **B. The Medicaid Eligibility Group**

The Medicaid eligibility group for IHCC groups for Community Medicaid corresponds to the Medicaid eligibility unit – that is, individual (one) or couple (two) as follows:

- (1) **Single Adults** –A single adult requesting IHCC group Medicaid, including Medicaid LTSS, is treated as an “individual” – 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:
    - Until the first day of the month following the calendar month of death or separation, when one spouse dies or the couple separates;

- 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
  - When the resources of the couple are reassessed and allocated as of the date of application for Medicaid coverage of LTSS.
- (b) Exceptions. Adult applicants with spouses are treated as an “individual” for eligibility purposes in the following circumstances:
- When one spouse in a couple is receiving LTSS and applying for Medicaid, 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, though 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 LTSS in a subsequent month.
  - When the both spouses receive Community Medicaid and are residing in a residential care setting serving four 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, and supportive living arrangements for adults with developmental disabilities.
- (3) **Child (Applicable for Medically Needy Eligibility Only)** –The Medicaid eligibility group for a dependent child up to age nineteen (19) applying for medically needy 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 requesting SSI-related Medicaid, 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.

### **C. Formation of the FRU**

The financial responsibility group (FRU) consists of the persons whose income and resources are considered available to the Medicaid group in the eligibility determination. The following subsections set forth the rules for determining membership in the financial responsibility group and the portion of the group’s income considered available to the Medicaid group –

- (1) **FRU Composition for Citizens** – The FRU for citizens and non-citizens differs due to deeming requirements. For citizens, the FRU consists of the applicant 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. The FRU serves as the basis for income and resource deeming for persons seeking Community Medicaid.

- (a) FRU – Single Adults. The financial responsibility group for an adult requesting SSI-related Medicaid, including Medicaid LTSS, is the same as the adults Medicaid eligibility group.
- (b) FRU Child. The financial responsibility group for a dependent child requesting SSI-related Medicaid 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. 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. With some exceptions, spouses are considered financially responsible for one another. The FRU includes the applicant and spouse, even when the spouse is not applying for or is ineligible for Medicaid and any adult dependent children living in the household.
- (2) **FRU for Sponsored Non-citizens** – The FRU for a non-citizen admitted to the United States on or after August 22, 1996 based on a sponsorship under section 204 of the Immigration and Nationalization Act (INA) includes the income and resources of the sponsor and the sponsor’s spouse, if living with the sponsor, when all four of the following conditions are met:
- 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 to conform to the requirements of Section 213A(b) of INA;
  - The noncitizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for Medicaid following entry to the United States has ended;
  - The noncitizen is not battered; and
  - The noncitizen is not indigent, defined as unable to obtain food and shelter without assistance, because his or her sponsor is not providing adequate support.

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>

## **1405.00 IHCC Groups – Treatment of Income in the Financial Eligibility Determination**

### **A. Overview**

The SSI methodology uses countable income as the basis for determining whether a person who meets the characteristic and general eligibility requirements for an IHCC groups meets the limits established by the State for Medicaid health coverage. Countable income is the amount of earned and unearned income available to the person applying for (herein after the applicant) or renewing

(hereinafter the beneficiary) Medicaid health coverage subsequent to the deduction of standard and coverage-group specific disregards and exclusions and, as appropriate, the application of deeming rules.

## **B. Definitions**

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

**“Assistance Based on Need (ABON)”** means assistance provided under a program which uses income as a factor of eligibility and is funded wholly by a State. If a program uses income to determine payment amount but not eligibility, it is not ABON. Assistance Based on Need is excluded from income.

**“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. Income is usually available in the following situations:

- The person receives the income;
- Someone else receives the income on behalf of the person;
- The employer or other payer owes the person the money but withholds the income at the person's request or under a court order;
- Income is withheld from payments due to a garnishment or to pay a legal debt or obligation – child support payments, back taxes.

**“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.

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

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

**“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.

**“Income”** means cash or in-kind benefits available to a client and not established as an asset. Income is divided into two major categories, earned and unearned:

- *Earned* income is cash or in-kind benefits received in return for work or services, including employment and self-employment.

- *Unearned* income is cash or in-kind benefits received without being required to perform any work or service.

**“Income Based on Need (IBON)”** means assistance provided under a program which uses income as a factor of eligibility and is funded wholly or partially by the federal government or a non-government agency (e.g. Catholic Charities or the Salvation Army) for the purpose of meeting basic needs.

**“Ineligible Person”** means a parent, child or spouse of the applicant for 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.

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

### C. EOHHS Responsibilities

In calculating countable income, the EOHHS is responsible for reviewing all sources of income the applicant receives or may be eligible to receive. Different requirements apply when renewing eligibility as indicated below in Section 1403. When determining initial eligibility using the SSI methodology, EOHHS responsibilities include, but are not limited to, the following:

- (1) **Formation of the Financial Responsibility Unit** – The identification and then formation of the financial responsibility unit is the basis for determining whether the income and resources of persons other than the applicant are available and should be considered when determining financial eligibility using the SSI methodology.
- (2) **Evaluation of Income** – All income, earned and unearned, must be evaluated included any that is self-reported on the application form or that may become known to the EOHHS or its eligibility agent through authorized electronic data matches using information from other health and human services programs (e.g., SNAP, RI Works, etc.) and outside sources (State Wage Information Collection Agency or SWICA, SSA, DOH Vital Statistics, etc.).
- (3) **Exclusions** – Certain forms of earned and unearned income are excluded or treated as “not income” under federal law or regulations for the purposes of determining income eligibility. The State also excludes certain types of income allowed under the Medicaid State Plan and Section 1115 waiver. The EOHHS must assure that all exclusions are applied during the calculation of income.
- (4) **Application of Disregards** – There are both general and program-specific disregards that apply to earned and unearned income. EOHHS must apply the disregards in a specific order when calculating countable income.
- (5) **Deemed Income** – Non-LTSS only – When an applicant or potentially eligible person resides with a non-applicant or ineligible person who is a spouse or parent, a portion of the ineligible person’s income must be deemed as attributable and available to the

applicant/beneficiary. Attributable income is assumed to be available to an eligible individual. The deeming of income is subject to conditions and limitations. Section 1415, sets forth the deeming of income provisions.

- (6) **Determination of Income Eligibility** – The determination of eligibility must be made with the specific timeframes required for a specific IHCC coverage group. In instances in which a clinical disability or a level of care review is required, the State must complete the eligibility determination and provide notice in no more than ninety (90) days from the date the application is submitted. Supporting documentation from the applicant/beneficiary or their representatives must be provided within this timeframe. For all other the types of IHCC coverage, the eligibility determination must be made and notice provided in no more than thirty (30) days from the date the application is submitted.

The specific steps in the determination process for Community Medicaid are specified in Section 1405. Chapter 1500, section 1501, sets forth sequence of reviews in the process for determining eligibility for Medicaid LTSS. Determinations are based on the information provided in the application and all required documentation in accordance with general eligibility requirements, the rules for evaluating and counting income and resources, and the relevant standards and limits for the IHCC coverage group.

- (7) **Notice** – The EOHHS is responsible for providing notice to each applicant/beneficiary of the determination of eligibility. The notice must include the eligibility decision, the basis for the decision, the start and end date of the eligibility period, and the right to appeal and have hearing if dissatisfied with the outcome of the eligibility decision in accordance with rules in MCAR, Section 0110.

#### **D. Applicant Responsibilities**

- (1) **Access to Benefits** – A person must try to gain access to potentially available income as a condition of eligibility. Accordingly, applicants/beneficiaries seeking Medicaid coverage under this section must attest that they have applied for all forms of assistance for which they may be eligible and provide the required documentation related to disability determinations and other eligibility factors as indicated.
- (2) **Timely and Accurate Information** – All persons seeking initial or continuing Medicaid health coverage are required to provide timely and accurate information on all matters related to eligibility. Applicants and beneficiaries must report changes in eligibility factors such as income, resources, clinical status and condition, and household composition as well as changes in address and the like in no more than ten (10) days from the date the change occurs.

### **Section 1405.01. General Rules for the Treatment of Income**

#### **A. Scope and Purpose**

Income, whether earned or unearned, may be received in either of two forms, cash and in-kind.

- Cash includes currency, checks, money orders, or electronic funds transfers (EFT), such as Social Security checks; Unemployment compensation checks; and payroll checks or currency.
- In-kind includes noncash items such as real property; food; clothing; and non-cash wages (e.g., room and board as compensation for employment).

The purpose of this section is to establish the process and requirements for the evaluation and treatment of income when determining IHCC group eligibility.

## **B. Basic Income Counting Rules**

The determination of income eligibility using the SSI methodology follows a set sequence of calculations and certain rules as outlined below:

- (1) **Earned Income** – Both the source and amount of all earned income must be considered. Not all earned income counts when determining eligibility for Community Medicaid. The earned income disregards and exclusions are applied in the following order –
  - Income exclusions authorized by federal law are applied (See Section 1405).
  - Earned income tax credit payments (effective January 1, 1991) and child tax credit payments.
  - Up to \$30 of earned income in a calendar quarter if it is infrequent or irregular.
  - Earned income of person who is blind or impaired and a disabled student child up to the student earned income exclusion (SEIE) monthly limit, but not more than the SEIE yearly limit.
  - Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month.
  - Sixty-five dollars (\$65) of earned income in a month.
  - Earned income of disabled individuals used to pay impairment-related work expenses.
  - One-half of remaining earned income in a month.
  - Earned income of blind individuals used to meet work expenses.
  - Any earned income used to fulfill an approved plan to achieve self-support (PASS).
- (2) **Unearned Income** – Unearned income is counted as income in the earliest month it is received by the individual; credited to a person’s account; or set aside for the person’s use. There is also a sequence for evaluating unearned income that begins with the most common exclusions under federal law.
  - Any public agency’s refund of taxes on real property or food;
  - Assistance based on need which is wholly funded by a State;
  - Any portion of a grant, scholarship, fellowship, or gift used for paying tuition, fees, or other necessary educational expenses;
  - Food which an individual or his/her spouse raises if it is consumed by the household;

- Assistance received under the Disaster Relief and Energy Assistance Act and assistance provided under any Federal statute because of a presidentially-declared disaster;
- The first \$60 of infrequent or irregular unearned income received in a calendar quarter;
- Alaska Longevity Bonus payments;
- Foster care payments;
- 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;
- Certain home energy and other needs-based support and maintenance assistance;
- One-third of child support payments made by an absent parent;
- \$20 general income exclusion;
- Income used to fulfill an approved plan to achieve self-support;
- Federal housing assistance;
- Any interest on excluded burial space purchase agreement if left to accumulate as part of the value of the agreement;
- The value of any commercial transportation ticket which is received as a gift and is not converted to cash;
- Crime victims compensation;
- Relocation assistance;
- Hostile fire pay received from the Uniformed Services;
- Interest on a dedicated account which is excluded from resources;
- Gifts to children with life-threatening conditions;
- Interest and dividend income from a countable resource or from a resource excluded under a Federal statute other than section 1613(a) of the Social Security Act;
- State annuities for certain veterans.

### **C. Both Earned and Unearned Income Exclusions**

Certain exclusions apply only to earned income, some apply only to unearned income and a few apply to both earned and unearned income. The following disregards apply to both earned and unearned income:

- (1) **Infrequent/Irregular Income Exclusions** –Income which is received infrequently and irregularly is disregard provided the total income excluded does not exceed:
  - \$0/month of earned income; and/or
  - \$20/month of unearned income.

This exclusion applies to both earned and unearned income in the same month provided the total of each does not exceed the allowed limits. Thus it is possible to exclude as much as \$30 in a month under this provision.

- (2) **\$20/Month General Income Disregard** –The first \$20 per month of unearned income is deducted from income.

- The \$20 is applied to earned income only if the \$20 cannot be applied to unearned income. The dollar amount of this exclusion is not increased when an eligible person and eligible spouse both have income.

- An eligible couple receives one \$20 exclusion per month.

(3) **PASS Exclusion** - Income, whether earned or unearned, of a blind or disabled recipient 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.

#### **D. Earned Income Exclusions**

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income. Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

(1) **\$65 and 1/2 Earned Income Exclusions** – If the applicant or spouse is employed, earned income of \$65/month plus one half (1/2) of the balance is excluded. When both eligible spouses are employed, this exclusion is applied to only one earned income.

(2) **Impairment-Related Work Expenses** – Impairment related work expenses are deducted provided:

- The person is under age 65 and disabled (but not blind), or received SSI or RI General Public assistance based on a disability for the month before attaining age 65;
- The severity of the impairment requires the person to purchase or rent items and services in order to work;
- The expense is reasonable;
- The cost is paid in cash (including checks, money orders, credit cards and/or charge cards) by the person and is not reimbursable from another source (e.g., Medicare, private insurance); and
- The payment is made in a month the person receives earned income for a month in which he or she both worked and received the services or used the item, or the person is working but makes a payment before the earned income is received.

(3) **Work Expenses of Blind Persons** –The following expenses related to a blind person's employment are excluded:

- Transportation Expenses. Bus, cab fare, instructions for use of cane; cost/upkeep

of guide dog; private automobile.

- Job Performance. Braille instruction; child care costs; equipment needed on job (e.g., for homebound work); instructions in grammar (if work related); licenses; lunch; prosthesis needed for work even though not related to blindness; optical aids; reader; safety shoes; income (federal, state, local) taxes; FICA taxes; self-employment taxes; translation of material into Braille; uniforms and care of them; union dues; wheelchair if necessary due to other disability.
- Job Improvement. Computer program training, skills enhancement, etc.

Further expenses are disregarded if the person has an approved plan for self-support. The amounts must be reasonable and not exceed the earned income of the blind person or a blind spouse.

- (4) **Earned Income Tax Credit** – The earned income tax credit (EITC), a special tax credit for certain low income working taxpayers, is excluded. This tax credit may or may not result in a payment to the taxpayer. EITC payments can be received as an advance from the employer or as a refund from the IRS.
- (5) **Student Child Earned Income Exclusions** – For a child under age 22 who is blind or impaired and a student regularly attending school, up to \$400/month of earned income (but not more than \$1620 in a calendar year) is excluded.
- (6) **Child Care Tax Credit** – A credit given to taxpayers at the end of the tax year for each dependent child who is under the age of 17. The credit is nonrefundable and reduces the taxpayer's liability on a dollar-for-dollar basis.

## **E. Unearned Income Exclusions**

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

- *IBON* – If a program is funded by the federal government or a private or not-for-profit organization in using income to determine eligibility, it is considered Income Based on Need. IBON is counted as income dollar for dollar unless it is totally excluded by statute (e.g., SNAP) or excluded under PASS.
- *ABON* – If a program funded wholly by the State that uses income to determine eligibility, it is Assistance Based on Need or ABON. Assistance Based on Need is excluded from income.

Using this distinction, this subsection details the most common unearned income exclusions and provides a general summary of all that apply under federal law:

- (1) **RI Works Under a PASS** – RI Works payments under a PASS are excluded. However,

RI Works payments are based on need and, unless excluded under a PASS, are countable income. The \$20 general income exclusion does not apply to this income.

(2) **Foster Care Payments** – The treatment of foster care income varies by funding source:

- Foster Care payments made under Title IV-E of the Social Security Act are federally funded and thus IBON for child care purposes to the child in care. This income is not subject to the \$20 general exclusion. The total payment is counted.
- Foster Care payments provided under Title IV-B or Title XX of the Social Security Act are social services and are excluded from the foster child's income.

(3) **Adoption Assistance** – Adoption Assistance provides additional financial help to families who adopt certain children with special needs. Income is a factor in determining the amount of adoption assistance, but not eligibility for the program. Adoption assistance involving Title IV-E funds is IBON to the adopted child. The income is not subject to the \$20 general exclusion and is counted dollar for dollar.

(4) **Support Payments** – Alimony and support payments are cash or in-kind contributions to meet some or all of a person's need for food, clothing or shelter. Alimony, spousal and other adult support payments are unearned income to the parent. Child support payments are unearned income to the child. However, one-third of a child support payment made to or for an eligible child by an absent parent is excluded. A parent is considered absent if the parent and the child do not reside in the same household.

(5) **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 qualified education expenses (tuition, fees or books, etc) is excluded income. This exclusion does not apply to any portion set aside or actually used for room and board.

(6) **Student Loans** – Federal and state funds or insurance are provided for educational programs at middle school, secondary school, undergraduate and graduate levels under Title IV of the Higher Education Act and student assistant programs of the Bureau of Indian Affairs.

Any loan to an undergraduate student for qualified education expenses made and/insurance by the federal government or the State's higher education financing authority is excluded as both an income and resource.

(7) **Interest Earned on Burial Fund** – 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 left to accumulate. If not left to accumulate (e.g., paid directly to the person, spouse or parent), the receipt of the interest may result in countable income.

(8) **Death Benefits** – A death benefit is something received as the result of another's death.

- Proceeds of a life insurance policy received due to the death of the insured;
- Lump sum death benefit from SSA;
- Railroad Retirement burial benefits;
- VA burial benefits;
- Inheritances in cash or in-kind;
- Cash or in-kind gifts given by relatives, friends or a community group to "help out" with expenses related to the death.

\* Death benefits are excluded to the extent the beneficiary paid the expenses of the deceased's last illness and burial expenses. Recurring survivor benefits such as those received under RSDI and private pension programs etc. are not death benefits.

(9) **Home Energy Assistance Payment** – 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.

(10) **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.

(11) **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:

- The United States Housing Act of 1937 (Section 8);
- The National Housing Act;
- Section 101 of the Housing and Urban Development Act of 1965;
- Title V of the Housing Act of 1949; or,

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

(12) **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.

(13) **Refugee Cash Assistance** – Refugee cash assistance payments and federally reimbursed general assistance payments to refugees may be excluded. The payment may be excluded under a PASS; otherwise it is IBON and is counted. The \$20 general income exclusion does not apply to this income.

(14) **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.

(15) **Certain Reparation Payments** – Reparations associated with the following are excluded from income:

- Reparation payments received from the Federal Republic of Germany;
- Austrian social insurance payments based in whole or in part on wage credits granted under the Austrian General Social Insurance Act;
- 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
- Agent Orange settlement payments.

(16) **Comprehensive List Unearned Disregards** – In addition to the most common unearned exclusions detailed in this section, there are several other areas where exclusions apply as a matter of federal law. The chart below identifies both the most common exclusions as well as other required disregards.

<b>Comprehensive List of Unearned Income Exclusions</b>	
Agent Orange Settlement Payments	Japanese – American and Aleutian Restitution Payments
Alaska Longevity Bonus Payments Alaska longevity bonus payments made to an individual who is a resident of Alaska and who, prior to October 1, 1985, met the twenty-five-year residency requirement for receipt of such payments in effect prior to January 1, 1983, and was eligible for supplemental security income (SSI);	Leveraging Educational Assistance Program (LEAP)
AmeriCorps and National Civilian Community Corps (NCC) Payments	Low Income Energy of Assistance
AmeriCorps*Vista	Meals for Older Americans
Austrian Social Insurance Payments	Milk Programs
Burial Funds, Interest on Excluded	Nazi Persecution, Payments to Victims of

<b>Comprehensive List of Unearned Income Exclusions</b>	
Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which are left to accumulate and become part of separate burial funds, and interest accrued on and left to accumulate as part of the value of agreements representing the purchase of excluded burial spaces, as described in 20 C.F.R. 416.1124(c)(9) and (15) (as in effect on March 1, 2014);	
Child Care Assistance Under the Child Care and Development Block Grant Act	Netherlands WUV Payments to Victims of Persecution
Child Support The amount of court-ordered child support payments paid by a household member for a child outside the home	North Vietnam, DOD Payments to Certain Persons Captured and Interned
Clinical Trial Participation Payments	Pell Grants
Corporation for National and Community Service (Formerly ACTION) Programs	Private Nonprofit Assistance
Department of Education (DE) and Bureau of Indian Affairs (BIA) Student Assistance	Radiation Exposure Compensation Trust Fund (RECTF) Payments
Disaster Assistance Disaster assistance as described in 20 C.F.R. 416.1150 and 416.1151 (as in effect on March 1, 2014);	Refunds of Taxes Paid on Real Property or Food Refunds of federal income taxes and advances made by an employer relating to an earned income tax credit, as provided in 20 C.F.R. 416.1112(c) (as in effect on March 1, 2014);
Dividends and Interest Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than section 1613(a) of the Social Security Act, in accordance with 20 C.F.R. 416.1124(c)(22) (as in effect on March 1, 2014);	Relocation Assistance
Educational Assistance	Retired Senior Volunteer Program (RSVP)
Energy Assistance Energy Employees Occupational Illness Program (EEOICP)	Ricky Ray Hemophilia Relief Fund Payments
Federal Perkins Loan	Rural Housing Service (RHS), formerly Farmers Home Administration
Federal Supplemental Education Opportunity Grants (FSEOG)	School Breakfasts
Filipino Veterans Equity Compensation Fund (FVECF) Payment	School Lunches
Food/Meal Programs The value of food assistance and the value of foods donated by the department of agriculture;	Senior Companion Program
Food Stamps	Special and Demonstration Volunteer Program
Foster Grandparents Program	State Annuities for Certain Veterans
General Assistance	State Assistance Based on Need
Gifts Occasioned by a Death	University Year for ACTION (UYA)
Gifts of Domestic Travel Tickets	Veterans' Children with Certain Birth Defects, Payments to
Grants, Scholarship, Fellowships, and Gifts	Victims' Compensation Payments
HUD Subsidies	Women, Infants, and Children Program (WIC)
Home Energy Assistance	Individual Development Accounts (IDAs) – Demonstration Project
Home Produce	Individual Development Accounts (IDAs) – TANF Funded
Housing Assistance Relocation assistance, as described in 20 C.F.R. 416.1124(c)(18) (as in effect on March 1, 2014);	Hostile Fire Pay from the Uniformed Services

## **F. Lump Sum Income**

Lump sum income is irregularly or infrequently received income. It can be earned or unearned income. Whether lump sum income is counted when determining income 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:

- Winnings (lottery, gambling). Insurance settlements.
- Worker's Compensation Settlements. Inheritances. Retroactive payments of RSDI, VA, and Unemployment Insurance

(1) **General Treatment of Lump Sum Income** – For all IHCC groups, the following are excluded from lump sum income:

- Costs associated with getting the lump sum, such as attorney's fees;
- Any portion of the lump sum earmarked for and used to pay health expenses not covered by Medicaid or another form of insurance
- Any portion of the lump sum recovered by the EOHHS or its agents.
- Any portion of the lump sum earmarked for and used to pay funeral and burial costs paid upon the death of a spouse or child.

(2) **RSDI and SSI Payments** – When eligibility for RSDI and SSI benefits are first approved, recipients 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 persons 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 dependent benefits is counted as unearned income to the dependent in the month received.

(b) **Community Medicaid, MPPP, and Medicaid LTSS pathways.**

- Retroactive RSDI lump sum payments are counted as unearned income in the month received. If the beneficiary is not receiving SSI, the RSDI payment counts as a resource in the following month if retained
- Retroactive lump sum payments of SSI are excluded as income and resources in

the month received.

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

(3) **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 Centers for Medicare and Medicaid 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.

## **G. Self-Employment Income**

Self-employed beneficiaries who generally work for themselves rather than for an employer, are responsible for their own work schedule, and are not covered under an employer's liability insurance or Workers' Compensation. Depending on the type of self-employment, a beneficiary may or may not have Social Security tax (FICA) deducted from pay.

Examples of self-employment enterprises include: Farming; Product Sales (e.g., involving personal goods such as jewelry, household goods, clothing and the like); Personal Training; Professional Consulting; Small businesses; Services (e.g., personal care or day care); and Skilled Trades (e.g., roofers, painters, home design, etc.). The process for evaluating self-employed income includes:

- (1) **Treatment of self-employment income in general** – Self-employment income is reported as earned or unearned on the application and is generally accepted unless conflicts are identified. Net self-reported income – gross self-income minus allowable deductions for business – is counted as earned income.
- (2) **Treatment of property related self-employment income** – Certain types of self-employment involve use of real property. Deductions from gross self-employment income for allowable expenses are made in accordance with federal Internal Revenue Service (IRS) requirements associated with the business use of the home/vehicle. Special treatment is required with the following:
  - (a) Rental income. Income from rental property is counted as earned income only in those months the applicant/beneficiary spends an average of at least 10 hours per week maintaining or managing the property. Otherwise, rent is treated as earned 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.
  - (b) Room/Board Income. Roomer/boarder situations include the following:
    - A roomer lives with the household and pays for lodging only.

- A boarder eats with the household and pays for meals only.
- A roomer and boarder lives and eats with the household and pays for lodging and meals.

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

- (c) **In-home Day Care.** When an applicant/beneficiary provide 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 as they are not ABON.

## **H. Availability**

In evaluating income, whether it is available affects how it is counted. Specifically, under certain circumstances, the amount of income which must be determined as available may be greater than the amount a person will be able to use.

- (1) **Support Payments** – When an individual has been court-ordered to pay child support and/or spousal support to a former spouse, these payments must not be 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 income to the applicant/beneficiary.
- (2) **Income Deductions** – Court ordered income deductions must be 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 paragraph.
- (3) **Loan Deductions** – Deduction due to a repayment of an overpayment, loan, or other debt must be 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.

## Section 1405.02. Income Deeming

### A. Scope and Purpose

Deeming is the process of attributing all or a portion of the income and resources of non-applicant members of the FRU to the person seeking IHCC Community Medicaid. There are two situations in which deeming occurs:

- A non-applicant spouse (the *ineligible* or *disqualified* spouse) lives in the same household as the adult applicant and is included in the FRU;
- One or more of the non-applicant parents (*ineligible* parent(s)) reside with a dependent child who is seeking Medically Needy coverage is part of the FRU.

There is no deeming in determining eligibility for Medicaid LTSS. This provision sets forth in this section provide the formula for calculating the amount of income that the ineligible spouse or parent is responsible to deem to an otherwise-eligible spouse or child.

### B. Definitions

For the purposes of deeming, the following definitions apply:

**"Allocation"** means an amount deducted from income subject to deeming, which is considered to be set aside for the support of members of the FRU other than the eligible individual.

**"Applicant"** means the person seeking initial or continuing eligibility for Medicaid. Applicant is a member of the FRU and may be a:

- **"Child"** under age of eighteen (18) or nineteen (19), if enrolled in school full-time, who lives in a household with one or both parents and is neither married nor the head of household and has income above the MACC group income limit of 261% of the FPL. Such a child is eligible to apply for Medically Needy coverage through the IHCC group eligibility pathway.
- **"Parent"** is a person, as defined below, who is seeking coverage and lives in the same household with a dependent child in the FRU who is not eligible for Medicaid.
- **"Spouse"** is the member of the married couple who has applied for and found to meet the general and financial criteria for IHCC group coverage.
- **Sponsored non-citizen** is the person whose eligibility is tied to non-applicant sponsor, typically a parent or spouse in the FRU.

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

**"Deemor"** means a member of the FRU whose income and/or resources are subject to deeming. Such individuals include ineligible parents, sponsors of non-citizens, ineligible spouses, and essential persons. It does not matter whether these individuals have sufficient income or resources to deem; they are still considered to be deemors. The type of income such an individual receives does not exclude him or her from this definition.

**"Household"** means the eligible person and spouse, any of the couple's children or the children of either member of the couple, the eligible child, the eligible child's parent(s), other children of the parent(s), and/or the eligible person included in the FRU.

**"Non-Applicant or NA"** means a child, parent, sponsor or spouse include in the FRU whose finances are considered for deeming purposes but is not seeking or does not qualify for IHCC Medicaid.

**"Parent"** means a natural or adoptive father or mother living in the same household as the eligible child. The income of a stepparent who lives with the eligible child is deemed to the child only when the natural or adoptive parent also lives in the household with the stepparent and the child. If the natural or adoptive parent divorces a stepparent and the child is living with the stepparent, the stepparent is not included in the FRU and is not considered for deeming purposes.

**"Sponsor"** means a person individual who signs an affidavit of support agreeing to support a non-citizen as a condition of the person's admission for permanent residence in the U.S.

**"Spouse"** means a person who is legally married to another under Rhode Island law.

### **C. Income Deeming Process**

(1) **Excluded income** –When determining the income of non-applicant members of the FRU – NA spouse, NA parent, NA sponsor, or NA child – the following items are not considered income:

- (a) Income excluded by federal laws other than the Social Security Act. The full list of income excluded is set forth in the summary located in Section 140??
- (b) Public income – maintenance. Any public income-maintenance received by the non-applicant members of the FRU, and any income which was counted or excluded in figuring the amount of that payment. Also excluded is any of the income of the NA spouse or parent that is used to determine the amount of a public income-maintenance payment to someone else. For these purposes, public income-maintenance payments are as follows:
  - RI Works cash assistance provided under Title IV-A of the Social Security Act, Temporary Assistance for Needy Families (TANF);
  - SSI and/or SSP payments authorized by Title XVI of the Social Security Act, include mandatory and optional payments administered by the SSA and/or the State;

- Refugee cash assistance, when based on need, reimbursed to the State under the Refugee Act of 1980;
- Disaster Relief provided in conjunction with a federally declared disaster under the federal Disaster Relief and Emergency Assistance Act
- General assistance available through programs of the Bureau of Indian Affairs
- General Public Assistance (GPA) payments and other ABON provided through State government assistance programs based on need (tax credits or refunds are not assistance based on need)
- Veteran's pensions and assistance available through the U.S. Department of Veterans Affairs when those payments are based on need-only.

(c) Other forms of income. Excluded as follows:

- Education assistance. Any portion of a grant, scholarship, fellowship, or gift used or set aside to pay tuition, fees or other necessary educational expenses;
- Foster Care. Money received for providing foster care to an ineligible child;
- Food and nutrition assistance. The value of food cash assistance provided through SNAP, WIC and comparable state-only programs and the value of donated foods;
- Tax refunds. Whether based on income, real property, or food purchased by the family;
- PASS. Income used to fulfill an approved plan for achieving self-support (PASS);
- Child support. The amount of court-ordered child support payments paid by a member of the FRU for a child outside the home.
- In-kind Income. The value of in-kind support and maintenance;
- Blind work expenses of the ineligible spouse or parent;
- Personal Care. Income of the non-applicant spouse or parent which was paid under a federal, state, or local government program to provide the applicant/beneficiary with chore, attendant or homemaker services;
- Housing assistance. Federal and/or State housing assistance as specified in 20 C.F.R. 416.1124(c)(14) and updated on an annual basis;
- Travel. The value of a commercial transportation ticket unless the ticket is converted to cash; the cash is income in the month the spouse or parent receives the cash;

- Income tax advances. Refunds of federal income taxes and advances for the earned income tax credit;
- Victims' compensation funds. Any such assistance provided to an ineligible member of the FRU through a State or local fund;
- Relocation assistance;
- Combat pay. Payments to any ineligible member of the FRU received from one of the uniformed services;
- Impairment-related work expenses. Any expenses incurred and paid by an ineligible spouse or parent, if the ineligible spouse or parent receives disability benefits under title II of the Social Security Act;
- Burial funds. Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which are left to accumulate and interest accrued on and left to accumulate as part of the value of agreements for the purchase of excluded burial spaces;
- Interest and dividend income. Any such income from a countable resource or from a resource excluded under a federal statute other than Section 1613(a) of the Social Security Act; and
- Student earned income.

(2) **Deeming Rules** – The process for determining deemed income proceeds through the steps below:

(a) **Public income-maintenance.** If the eligible spouse or parent(s) is/are receiving RI Works, General Public Assistance (GPA), SSI or SSP payments, then the payments themselves and any of the eligible person's own income that was used to compute eligibility for such payments are not considered available for deeming. The income of a spouse or parent who does not receive one of these forms of cash assistance is considered available and must be deemed even if the income was used to determine eligibility for another member of the household.

(b) **General Limits.** In general, income is not deemed from:

- A child to a parent.
- A sibling to another sibling, or other children under 21 living in the household.
- A stepparent to a stepchild.
- A grandparent to a grandchild.
- A non-parent relative caretaker to a child.

- Other people to an applicant who has automatic eligibility for Medicaid (SSI, SSP, foster care child) or automatic MA or other deeming exceptions.
- (3) Adult Deeming – When the NA spouse is a member of the FRU, the following steps to are used to calculate the amount of income to deem to the applicant/beneficiary:
- (a) The NA spouse's income is calculated applying any appropriate exclusions;
  - (b) The appropriate allocation for the NA spouse included in the FRU is deducted. The allocation amount is the current SSI federal benefit rate (FBR), as published annually in the Federal Register, for a couple minus the current FBR for an individual.
  - (c) The allocation for each NA child or sponsored non-citizen in the FRU is reduced by the income of that child or non-citizen, minus any appropriate exclusions.
  - (d) The allocation of the NA child or non-citizen must first be taken from the NA spouse's unearned income; any remaining allocation is subtracted from the NA spouse's earned income.
  - (e) If the NA spouse's remaining income after subtracting the NA child or sponsored non-citizen allocation is less than or equal to the current FBR for a couple minus the current FBR for an individual:
    - No income is deemed the applicant/beneficiary;
    - The applicant's own income is compared to the current Medicaid eligibility group standard for an individual.
  - (f) If the NA spouse's remaining income after subtracting the NA child or sponsored non-citizen allocation is greater than the current FBR for a couple minus the current FBR for an individual, the spouses are treated as if they were an eligible couple:
    - Both spouses' post-allocation earned and unearned incomes are combined;
    - The twenty-dollar (\$20) general disregard is subtracted from the unearned income; if there is less than twenty dollars of unearned income, the rest of the unearned income disregard is subtracted from the earned income;
    - Sixty-five (65) dollars is subtracted from earned income, then one-half is subtracted of the remaining earned income.
  - (g) If the couple's countable income is less than or equal to the current standard for the Medicaid eligibility group for two, the applicant is income eligible for Community

Medicaid. If the couple's countable income is above the Medicaid income eligibility limit for a couple, the applicant/beneficiary may opt for Medically Needy coverage.

(c) Deeming – Child. When an eligible child or children reside(s) with an NA parent or parents, perform the following steps to calculate the amount of income to deem to the child(ren):

(01) The income of the NA parent(s) is determine, applying any appropriate exclusions;

(02) The appropriate allocation is deducted for each NA child in the FRU and for each eligible non-citizen sponsored by the NA parent:

- There is no allocation for an NA child receiving income-maintenance payments;
- The allocation amount is the current FBR for a couple minus the current FBR for an individual;
- The allocation for each NA child or sponsored non-citizen in the FRU is reduced by the amount of their respective income;
- The allocations for the NA child or sponsored non-citizen allocation(s) must first be taken from the unearned income of the NA parent(s); any remaining allocation amount are subtracted from the earned income of the NA parent(s).
- The twenty-dollar (\$20) general disregard is subtracted from the unearned income of the NA parent(s); if there is less than twenty dollars of unearned income, the rest of the disregard is subtracted from the earned income of the NA parent(s).
- Sixty-five (65) dollars is subtracted from the earned income of the NA parent(s), and then one-half of the remaining earned income is subtracted.
- The NA parents' remaining earned and unearned income are combined.

(03) The parental living allowance is subtracted:

- There is no parental living allowance deducted for any parent who receives income-maintenance payments as defined in this section;
- If two parents (or one parent and a step-parent) are in the FRU, the current FBR for a couple is subtracted;
- If one parent is included in the FRU, the FBR for an individual is subtracted;

- If both natural or adoptive parents and a step-parent are included in the FRU, both the current FBR for a couple and the current FBR for an individual are subtracted.
- (04) The remaining income of the FRU is divided by the number of eligible children in the household, and the resulting amount is deemed to each child.
- (05) Any income deemed to a child from an NA parent is added to the child's own unearned income.
- (06) The twenty-dollar (\$20) general disregard from the child's unearned income; if the child has less than twenty dollars of unearned income, the remainder of the disregard is subtracted from the child's earned income.
- (07) Sixty-five dollars from the child's earned income is subtracted and then one-half of the remaining earned income is subtracted.
- (08) The child's earned and unearned income is combined.
- (09) If the result is more than the current Medicaid need standard for an individual, the child is Medically Needy to subject to spenddown provisions.

## **Section 1410.00 Treatment of Resources in Financial Eligibility Determinations**

### **A. Overview**

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*. Resources are counted based upon their availability and the ease with which an item can be converted into cash to pay for such necessities. The equity value of a resource, the amount its worth minus any debt or depreciation, is also a factor when assessing the amount of a resource that counts. Moreover, all resources of the members of the FRU must be counted unless specifically excluded and deeming sometimes applies. However, resources are counted only if applicants have the right, authority, or power to liquidate a resource or their share of the resource. Due to all these factors – which resources are reviewed, whether they are available, how much they are valued – the evaluation of resources is one of the more complex aspects of Medicaid eligibility determinations.

With the implementation of RI Bridges integrated eligibility system, the process for evaluating resources has been automated and streamlined to reduce the burden on applicants and beneficiaries to the fullest extent allowed under current federal law and regulations and the State's Section 1115 demonstration waiver. Verification requirements have also been revised to ensure program integrity and, at the same, take full advantage of the flexibility RI Bridges offers for electronic documents management. Most important, RI Bridges has the capacity to adapt the SSI methodology for evaluating resources to apply different standards of review when determining

financial eligibility for Community versus LTSS Medicaid coverage. As is explained below, the treatment of resources, while still complicated, is now better suited to a health coverage rather than cash assistance program.

## **B. Scope and Purpose**

This section describes the SSI-methodology resource requirements for the IHCC groups and sets forth the specific provisions governing the treatment of resources when determining eligibility for Community Medicaid.

Resources are treated in different ways depending on the IHCC group, whether the full or a simplified review using the SSI-method is required and if the IHCC group includes LTSS coverage. In addition, beneficiaries with IHCC group eligibility based on another federal or state are generally not subject to the provisions of this section. The differences in the treatment of resources on this basis are as follows:

- (1) **Simplified Resource Review for EAD** – Federal regulations (see 42 CFR ????) authorize states who expand eligibility for low-income elders and adults with disabilities up to 100 percent of the FPL 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 Rhode Island, the simplified standard applies to Community Medicaid members eligible through the EAD and medically needy pathways. Note income and resource deeming is included in the simplified standard in RI. The rules for the treatment of resources for Community Medicaid based on this general review are set forth in Section 1411.
- (2) **Comprehensive Resource Review for LTSS** – There are both MAGI and SSI-related eligibility pathways for LTSS that differ in terms of the treatment of income and resource limits, at least at the point in which an institutional level of care becomes required. Applicants evaluated using the SSI method (IHCC groups) are subject to a resource review; the resources of applicants seeking coverage through a MAGI pathway (MACC groups) are not an eligibility factor and 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. The specific provisions applicable to the evaluation of resources for Medicaid LTSS are set forth in MCAR, Section 1508.
- (3) **Coverage Groups Exempt** – Certain IHCC groups and individuals are exempt from the provisions of this section because they either do not have a resource limit under applicable laws and/or the Medicaid State Plan or the State’s 1115 waiver; or their eligibility is tied to another federal or state program and they have a resource limit established under another program that is accepted for Medicaid eligibility purposes. The provisions set forth in this section therefore do not apply to the following:

- All beneficiaries automatically eligible for Medicaid on the basis of the current or past receipt of SSI unless otherwise indicated in Section 1402 (F).
- Beneficiaries receiving Transitional Medical Assistance (TMA) under Section 0342.50.
- Beneficiaries eligible for the SSI-related coverage groups with 1619(b) status, pursuant to Section 1402.01(C)(4).
- Women eligible for the IHCC coverage group for women who have met the eligibility criteria established by the RI Department of Health related to treatment for breast and/or cervical cancer in accordance with Section 1402.03 (B).
- Children and youth eligible for Medicaid through the RI Department of Children, Youth and Families in conjunction with the foster care provisions under Title IV-E of the Social Security Act or the provisions of the Chafee Act.
- Medicaid beneficiaries receiving refugee cash assistance through the RI Department of Human Services.

### **C. EOHHS Responsibilities**

When using the SSI-methodology for determining Medicaid, resources are cash and other property, real or personal, that an applicant or beneficiary (individual or couple) own, have access to and the authority or power to convert to cash, and are available to be used for income support and maintenance. In calculating countable resources, EOHHS responsibilities include, but are not limited to:

- (1) **Scope of Evaluation** – The resources of the applicant/couple and each member of the FRU when deeming applies are evaluated at the time of initial application, when a beneficiary reports or the EOHHS receives information about a change in conjunction with the annual renewal of Medicaid eligibility, and when applying for Medicaid LTSS or moving across coverage categories.
- (2) **Factors Affecting the Evaluation of Resources** – The EOHHS must consider the following factors 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 purpose.
  - (c) **Equity value.** Equity value is considered when determining the amount of a resource

that counts. In general, equity value means the price an item can be reasonably expected to sell for on the local open market minus any encumbrances.

(d) **Countable v. Excluded Resources.** A resource may be counted or excluded for eligibility purposes. The EOHHS 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 –

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

(3) **Deemed Resources – non-LTSS only** – The EOHHS must evaluate the resources of all members of the FRU (non-applicant spouse/parent) and attribute any that are countable to the applicant(s) (individual or couple) in the deeming process when appropriate. For Community Medicaid, the deeming of countable resources of non-applicants in the FRU is required unless certain exemptions apply. For Medicaid LTSS, there is no deeming and the evaluation of resources is always based on the applicant or individual - that is, an FRU and Medicaid eligibility unit size of one – unless both spouses are seeking coverage.

(4) **Determination of Resource Eligibility** – The EOHHS determines resource eligibility by comparing the countable resources of the FRU to the resource limits for the applicable IHCC group adjusted for the Medicaid eligibility unit size (e.g., Individual v. Couple for Community Medicaid).

### **C. Applicant’s Responsibilities**

Applicants and beneficiaries are responsible for:

- Providing accurate information about their resources in the application process;
- Submitting any necessary documentation and/or signed authorizations that may be necessary for verification purposes;
- Report to the EOHHS any changes in resources, as identified in Section 1410.01(C) (2) within ten (10) days from the date the change occurred.
- Converting any available liquid resources into cash, as required, to ensure adequate funds are available for personal support and income maintenance.

## Section 1411 Resources in General

### A. Scope and Purpose

Although there are a standard set of resources that are considered when determining SS-based eligibility for IHCC group health coverage, they vary by type and the way they are reviewed. This section provides an overview of the various type of resources considered across all IHCC groups and the general process for their review.

### B. Definitions

For the purposes of this section the following terms apply:

**“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.

**“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.

**“Burial Fund”** means any separately identifiable fund clearly designated for burial expenses, such clearly designated for expenses of an applicant or an applicant’s spouse related to burial, cremation or other burial-related expenses. Includes 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

**“Dependent”** means child, stepchild, or grandchild; parent, stepparent, or grandparent; aunt, uncle, niece, or nephew; brother or sister, stepbrother or stepsister, half-brother or half-sister; cousin; or in-law.

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

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

**“First of the Month (FOM)”** means the point in time in which the value of resources is evaluated. The amount of countable resources a person owns may change during the month, but will not be include in the resource calculation until the following month resource determination.

**“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.

**“Home”** means a residential property in which the applicant and/or applicant'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.

**“Intent to Return”** means an expression by an applicant 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 an authorized representative of the applicant in the form of a signed, written statement.

**“Life Insurance Policy”** means a contractual arrangement between a person and an insurer in which, in exchange for a premium, the insurer agrees to pay a set amount to a designated beneficiary upon the person’s death. Insurance policies may be *term* or *whole life* and issued on an individual or group basis.

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

**“Liquid Resources”** means cash or other personal property that can be converted to cash within 20 days. Liquid resources ordinarily include, but are not limited to, accounts in financial institutions; retirement funds; stocks, bonds, mutual funds, and money market funds; annuities; mortgages and promissory notes; and home equity conversion plans.

**“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. Real property, life estates, burial funds, and life insurance are some of the more common kinds of non-liquid resources.

**“Ownership Interest”** means the applicant 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.

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

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

**“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.

**“Residential Property”** means a physical structure or shelter in which an applicant and/or the applicant's spouse maintain an ownership interest and have the legal right to use as a home. Includes, but is not limited to, single- or multi-family dwellings, condominium apartments/townhouses, and mobile houses used as living residences on land or sea.

**“Resource”** means either real or personal property which the applicant or beneficiary is able to use either directly or by sale or conversion to provide for his/her basic needs for food, clothing, shelter or medical care

**“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.

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

**“Trust”** means property that belongs to one person that is legally held or managed by another person or organization.

### **C. Types of Resources**

The SSI-methodology generally divides resources into two categories – non-liquid and liquid resources. Except for cash, any kind of property may be either liquid or non-liquid. For the purposes of clarity, a third category has been added for resources 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) Real property. Land and generally whatever is erected, growing on, or affixed to land.
  - (b) Income producing property. Refers to any property that is used for the purposes of generating income or otherwise providing personal support and maintenance. Examples include livestock, farm land or garden plots
  - (c) Vehicle. 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 boat.
  - (d) Life estates. 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.
  - (e) 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). Term life insurance only provides a death benefit, protects

the insured person for predetermine amount of time and does not build cash value. 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 applicant, if the eligibility unit is an individual) or the applicant or spouse (couple) is the owner. Policies on the life of an applicant or applicant's spouse owned by another member of the FRU are only considered when deeming applies (non-LTSS).

- (f) Burial Funds. 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.

(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) Personal property. Includes personal effects and household goods as well as financial resources including those resources typically held in financial institutions which are in cash or payable in cash on demand, and financial instruments convertible into cash. Accounts in financial institutions such as banks and credit unions include, but are not limited to, savings accounts, checking accounts, joint fiduciary accounts, and certificates of deposit. Depository institutions may also manage mutual fund and money market fund accounts for depositors. Non-depository financial institutions, such as brokerage firms, investment firms, and finance companies, also offer certificates of deposits as well as accounts and services related to the purchase and sale of stocks, bonds, mutual funds, money market funds, and other investments.
- (b) Investments. Legal instruments authenticating an investment, such as stocks, bonds, mutual funds, and money market funds pay interest at specified intervals, sometimes pay dividends, and are convertible into cash either on demand or at maturity. Includes U. S. savings bonds, which are obligations of the U.S. Treasury and vary in value by type.
- (c) Annuities. A contract reflecting payment to an insurance company, bank, charitable organization, or other registered or licensed entity; it may also be a private contract between two parties. There are two phases to an annuity, each of which affects how it is treated as resource: An accumulation phase and a payout phase. Annuities also vary significantly by type, how beneficiaries are treated and how they accumulate and pay out money (e.g., lump sum v. scheduled, usually on a monthly basis.). All these factors influence whether the value of the annuity is counted or excluded.
- (d) Loans. A contract or written statement clearly indicating a borrower's indebtedness, the personal or real property used to secure the borrowed amount (collateral), if any,

and the terms of repayment

- (e) **Mortgages.** A debt instrument, secured by the collateral of specific piece of real estate property, that a borrower is obliged to pay back without paying the entire purchase price upfront by making a predetermined set of payments. A borrower is considered an owner for the purposes of determining Medicaid eligibility before the debt is paid-off as long as payments are being made. A mortgage owned by an individual, as the creditor, may be excluded as a resource if certain criteria are met.
  - (f) **Promissory notes.** Written promises to pay a certain sum of money to a certain person, the bearer, upon demand or on a specified date. A promissory note owned by an individual, as the bearer, may be excluded as a resource if certain criteria are met.
  - (g) **Retirement funds.** Any resource set aside by a member of the FRU of an applicant/beneficiary individual's financial responsibility group to be used for self-support upon their withdrawal from active life, service, or business. Retirement funds include but are not limited to certain annuities IRAs, Keogh plans, 401K plans, pensions, mutual funds, stocks, bonds, securities, money market accounts, whole life insurance, and annuities. The value of a retirement fund is the amount of money that can currently be withdrawn from the fund.
  - (h) **Education funds.** Resources set aside to pay for qualified education expenses such as 529 accounts and Coverdell Educational Savings Accounts. The full amount of such funds is typically excluded even if the beneficiary is a member of the FRU.
  - (i) **Health savings accounts (HSAs)** Accounts used to set aside funds to meet medical expenses. Unless the individual can demonstrate that the funds in their HSA are not available to them, the HSA is a countable resource.
- (3) **Resources managed by a third party** –Resources, liquid and non-liquid, managed by a third party include, but are not limited to, trusts, guardianship accounts, and retirement funds. Resources of a member of the financial responsibility group managed by a third party (e.g., trustee, guardian, conservator, or agent under a power of attorney) are considered available to the member as long as the member 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 member's behalf without the member's direction.
- (a) **Guardianship funds.** A person or institution appointed by a court in any state to act as a legal representative for another person, such as a minor or a person with disabilities. Guardianship funds are presumed to be available for the support and maintenance of the protected person. That person may rebut the presumption of the availability of guardianship funds by presenting evidence to the contrary, including, but not limited to, restrictive language in the court order establishing the account or in a subsequent court order regarding withdrawal of funds.
  - (b) **Power of attorney.** A written document signed by a person giving another person

authority to make decisions on behalf of the person signing it, according to the terms of the document. Rhode Island law requires a power of attorney to be executed according to certain formalities, such as being signed, witnessed, and acknowledged. Funds managed by an agent under a power of attorney are not property of the agent and cannot be counted as resources of the agent.

- (c) Representative payee. A person, agency, or institution selected by a court or the SSA to receive and manage benefits on behalf of another person. A representative payee has responsibilities to use these payments only for the benefit of that person, to notify the payer of any event that will affect the amount of benefits the person receives or circumstances that would affect the performance of the representative payee's responsibilities, and account periodically for the benefits received. Funds managed by a representative payee are not property of the representative payee and cannot be counted as resources of the representative payee.
- (d) Trust. A property interest usually that takes the form of fund comprised of a variety of liquid and non-liquid resources – e.g., cash, stocks, bonds, personal effects, life insurance, business interests, and real estate – that is held by a person or entity (called a “trustee”) who is legally responsible for ensuring the property owned by trust is used to benefit another person (the “trust beneficiary”). The person who transfers the resources to the trust is known as the “grantor”. In some instances, the grantor is also named as a trust beneficiary or “grantee. The treatment of a trust for Medicaid eligibility purposes depends on its type, whether the property it holds is accessible, and who in the FRU, if anyone, is the grantor, grantee and/or trustee.

## **Section 1411. 01 Resource Review Process**

### **A. 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

### **B. Process Rules**

The following process rules apply generally in the evaluation of resources across IHCC groups: subsection identifies and explains each of these features.

- (1) **First of the Month Rule** –Countable resources are determined as of the *first of the month* (FOM). The determination is based on the resources the person owns, their value, and whether or not they are excluded as of the first of the month.
- (2) **Resource Changes** – What a person owns in countable resources can change during a month, but the change is always effective with the following month's resource determination. The kinds of changes that may occur include:
  - (a) Changes in value of existing resources. The value of an existing resource may increase or decrease.

- (b) Disposition or acquisition of resources. A person may dispose of an existing resource (e.g., close a savings account and purchase an item) or may acquire a new resource (e.g., an inheritance which is subject to the income-counting rules in the month of receipt).
- (c) Change in exclusion status of existing resources. A person may replace an excluded resource with one that is not excluded (e.g., sell an excluded vehicle for non-excluded cash) or vice versa (use non-excluded cash to purchase an excluded automobile). Similarly, a time-limited exclusion (such as the period for exclusion of retroactive Title II – RSDI – benefits) may expire.
- (d) Change in resource form. The sale or transfer of a resource is treated as a change in the form of the resource rather than 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 expenditure on certain allowable expenses.
- (a) Community Medicaid. When a person seeking Community Medicaid has resources in excess of the general limits for a particular IHCC group, RI Bridges evaluates eligibility for other forms of coverage and, if none are available, issues a notice which explains the opportunity for resource reduction. In such instances, eligibility may be established by incurring and paying for a health care or other allowable expenses that equals or exceeds the amount of the excess resources. The expense and proof of payment must be provided within thirty (30) days of the notice of ineligibility.
- (b) Medicaid LTSS. For persons applying for Medicaid-funded LTSS, resource reduction is generally part of the application review process and is referred to as the pre-eligibility evaluation of medical expenses (PEME). See Section 1508.
- (c) Allowable expenses. In general, allowable expenses for resource reduction include:
- 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 eligibility. Certain LTSS home health care services are allowable expenses for Community Medicaid applicants when delivered by certified providers but only up to the amount EOHHS pays for the same or similar services on a fee-for-service basis. Special rules apply for Medicaid LTSS as indicated in Section 1509.
  - Tax payments based on assessments by the federal Internal Revenue Service, the Rhode Island Department of Revenue or, other State or municipal taxing authority.
  - 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.

- 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 evaluation to determine its countable value. Unless a resource is excluded, the ownership interest in a resource for FRU members is evaluate 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 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 members of the FRU must be evaluated. This rule applies to resources such as joint checking or savings accounts and real estate held in common. In instances in which the document creating the joint interests, such as a deed to real estate or a bank account signature card, specifies the shares of the parties, the fair market value of the entire resource is divided between the joint owners according to the shares specified. Attribution of jointly owned resources to members of the FRU is otherwise determined as indicated below –

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

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

(03) **Tenancy in its entirety.** The value of any resource owned in its entirety by a member of the FRU – e.g., joint savings account – is considered available to its

owner and is included for deeming in Community Medicaid and the allocation of resources for Medicaid LTSS.

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

(d) Prudent-person standard. The EOHHS uses the prudent-person standard when determining whether a lesser 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 to the applicant/beneficiary and members of the FRU. 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.

### **C. Mandatory Resource Exclusion**

(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. Many of these exclusions are the same as those required for income in 1405.01. Income from these sources accumulated in accounts in financial institutions must be segregated or clearly identified to be treated as excluded resources. The comprehensive list of mandatory resource exclusions is as follows:

- Federal means-tested benefits and State assistance benefits
- The value of meals and food commodities distributed under the National School Lunch Act and the Child Nutrition Act.
- The value of food or vouchers received through the WIC Program.
- The value of food or meals received under the Older Americans Act.
- Compensation or remuneration received for volunteer work in ACTION programs including foster grandparents, RSVP, SCORE, ACV, ACE, VISTA, Senior Companion Program and UYA.
- The value of assistance received under the U. S. Housing Act, U. S. Housing Authorization Act and the Housing and Urban Development Act.
- The value of relocation assistance to displaced persons under the Uniform Relocation and Real Property Acquisition Policies Act.
- Per Capital distributions to certain Indian Tribes and receipts from lands held in

trust for certain Indian Tribes.

- Payments received under the Alaskan Native Claims Settlement Act.
- Grants or loans received for educational purposes under any U. S. Department of Education program.
- Any assistance received under the Emergency Energy Conservation or Energy Crisis Program.
- Any assistance received under the Low-Income Home Energy Assistance Act, either in cash or through vendor payments.
- Compensation paid to Americans of Japanese or Aleut ancestry as restitution for their incarceration during World War II.
- Agent Orange Settlement payments.
- German reparations to concentration camp survivors, slave laborers, partisans, and other victims of the Holocaust. Settlement payments to victims of Nazi persecution or their legal heirs resulting from the confiscation of assets during World War II.
- War reparations paid under the Austrian government's pension system.
- Radiation Exposure Compensation Trust Fund payments.
- Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a Federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States. Comparable assistance received from a State or local government, or from a disaster assistance organization is excluded. Interest earned on the assistance is also excluded.
- Netherlands' Act on Benefits for Victims of Persecution 1940-1945 payments.
- Any account, including interest or other earnings on the account, established and maintained in accordance with section 1631(a)(2)(F) of the Social Security Act. These accounts are established with retroactive SSI payments made to a child under age 18 and used in ways specified in the Act. The exclusion continues after the child has reached age of 18.
- Earnings deposited in a special savings account authorized by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
- Payments as the result of a settlement in the case of Susan Walker v. Bayer Corporation, et al. made to hemophiliacs who contracted the HIV virus from contaminated blood products.
- The aid and attendance or special disability portion of Veteran's Administration

pension payments.

- (2) **Required by State law or regulation** – Educational savings accounts, including 529 and Coverdale accounts.

Citations to federal laws and regulations for exclude resources on this list are provided in the table in 1405.01 wherever applicable and available.

#### **D. Special and Limited-Time Exclusions**

There are a number of special and limited-time exclusions that apply that apply across the IHCC groups when using the SSI methodology for determining eligibility. Additional LTSS-specific time-limited exclusions are located in Chapter 1500. 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 Social Security Administration RSDI benefits are excluded for six (6) 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 is excluded when received from any source, including casualty insurance, for the purpose of repairing or replacing an excluded resource that is lost, stolen, or damaged, if used to replace or repair that resource. The exclusion is allowed for nine (9) months from the month of receipt 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 from consideration as resources in the year it is received.
- (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 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 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 period a limited period – not to exceed one year – in an a separate dedicated account for the purposes of home repairs/modifications that enable a for Medicaid LTSS beneficiary to continue to receive home-based care. Funds may only be used for such expenses not covered by a third-party, including Medicare, Medicaid and any federally or state-funded housing, and must be for spend 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 – i.e., estimates from a properly qualified 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.

#### **E. Determination of Resource Eligibility**

Once the appropriate exclusions have been applied and the value of each type of resource is determined for the FRU, the countable value of all resources (including deemed resources) are added together to determine the total countable resources for the Medicaid eligibility unit (individual or couple). If the resources of the Medicaid eligibility unit fall below or are equal to the applicable resource standard indicated in part (F) below, 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 Part (C)(2) of this Section or give away excess resources subject to the transfer of resources rule for Medicaid LTSS coverage as provided for in Chapter 1500.

**Section 1411.02 IHCC Group Resource Limits**

The following sets forth the review standard and general limits for Community Medicaid and LTSS as well as the limits that apply to the most common types of resources.

<b>IHCC Group Resource Limits and Exclusions Community Medicaid and LTSS</b>		
<b>Resource</b>	<b>Limits and Exclusions</b>	
	<b>Community Medicaid (EAD)</b>	<b>LTSS</b>
Total Limit –All Types of Resources	\$4,000 (Individual) \$6,000 (Couple)	\$2,000 (SSI Beneficiary) \$4,000 (All others)
Resources accumulated for personal support and maintenance:	Excluded	Excluded
Personal Affects and Household Goods	Up to \$5,000 in total net value excluded	Up to \$5,000 in total net value excluded
Vehicle	One vehicle, without regard to value; second vehicle,	One vehicle, without regard to value
Life Insurance	Face Value \$1,500 (Individual) Medically Needy Up to \$4,000	Up to \$1,500
Burial Funds	Revocable – \$1,500 Irrevocable – full amount excluded	Amounts above \$1,5000
Burial Space	Excluded	Excluded
Home and Adjoining Land	Excluded as resource if principal place of residence.	Excluded as resource if: principal place of residence; there is an intent to return; equity value does not exceed \$552,000.
SSI, SSP and RSDI Retroactive Payments	Up to six (6) months	Up to six (6) months

## **Section 1412.00 Treatment of Resources – Community Medicaid**

### **A. Scope and Purpose**

This section specifies the resources whose value are excluded in determining SSI-related Medicaid eligibility. The principal IHCC group subject to these provisions is Medicaid for elders and adults with disabilities (EAD) with income up to 100% of the FPL. The EAD general eligibility standards are also used for several of the SSI-related coverage groups, including the state-only supplement payment (SSP) and protected status groups (see Section 1400). The provisions of this section also apply to applicants and beneficiaries in these groups.

### **B. Simplified Review Process**

To facilitate the timely review of applications and determination of eligibility for Community Medicaid, the State has adopted a simplified review process for evaluating resources which does not consider information required for assessing the transfer of assets and any associated penalties.

### **C. Non-Liquid Resource Exclusions**

Certain types of non-liquid resource are excluded as resources when determining Medicaid eligibility. Most non-liquid resources are considered to “real” property such as a home, though there are types of “personal” property that fall into this category as well. For the purposes of determining financial eligibility for Community Medicaid, the treatment of these resources is listed below:

- (1) **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. The home includes contiguous land and any other buildings located on the land.
  - (a) **Home Exclusion.** A home in which the applicant or the spouse of an applicant has an ownership interest is excluded as resource, regardless of its value, when applying for EAD or medically needy Community Medicaid. The following conditions apply:
    - (01) **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 applicant or spouse with an ownership interest, sibling with an equity interest and/or dependent (minor child or relative with a disability) reside in the home for at least six (6) months and one day (183 days) in any given year.
    - (02) **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 applicant and the applicant's spouse/dependent child

make conflicting claims over which residential property is subject to the home exclusion the following decision rules apply:

- If the applicant and applicant's spouse live in separate residential properties in Rhode Island, in which they share ownership, the home exclusion applies to the residential property where the applicant lived at the time the application for Medicaid health coverage was received by the State.
- If each spouse lives in a separate residential property in Rhode Island, in which they share ownership, and both spouses apply for Medicaid, the home exclusion applies to the property where the spouse who applied first resides.
- If both applicants apply on the same day, the applicants 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.

- (03) Out-of-State Residences – To be eligible for Medicaid, an applicant 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.
- (04) Multi-State Residences – When an applicant 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.
- (05) Out-of-State property owner – If the applicant 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 applicant's spouse or dependent child.
- (b) Limitations on the Exclusion. In general, the home becomes a countable resource when the Medicaid applicant/ beneficiary with the ownership interest: moves out of the home and no spouse or dependent child remains, or does not reside in the home for the period required for it to remain the principal place of residence with the following exceptions:
- (01) 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.
- (02) Proceeds from the Sale – Once a home has been sold, the proceeds are excluded for six (6) months from the date they are received. Unless obligated or used for the

purchase, repair or construction of another domicile or another excluded resource, the proceeds become countable on the FOM in the month after the exclusion expires.

- (03) **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:
- (i) Intends to return to the home even if the likelihood of return is apparently nil;
  - (ii) Has a spouse or dependent residing in the home; or
  - (iii) Has a health condition that prevented the owner from living there before.
- (2) **Business/Trade Property** (real property) – Real estate used in business or a trade is exempt regardless of its equity value and whether it produces income.
- (3) **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.
- (4) **Vehicle** (personal property) – One vehicle that is used as the primary source of transportation for the applicant/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.
- (5) **Life estate** (real property) – 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 does not retain the power to sell or mortgage the home. If the owner does not retain this right, see Chapter 1500.
- (6) **Burial Funds** (personal property) – A burial fund is any separately identifiable fund clearly designated for burial expenses such as contracts, trusts, or other agreements, accounts, or instruments with a cash value. Irrevocable burial funds or prepaid contracts are unavailable and are excluded up to a maximum of \$15,000. Up to \$1,500 in a revocable burial fund or prepaid contract, and any accrued interest is excluded per member of the Medicaid eligibility group FRU, unless both an individual and spouse are applicants/beneficiaries – i.e., \$3,000 for a couple. The limit on value of revocable burial funds for a person seeking Medically Needy Community Medicaid eligibility is \$4,000.
- (7) **Burial Spaces** (personal property) – The value of a burial space is an excluded resource regardless of value.
- (8) **Personal Effects and Household Goods** (personal property) – Personal effects includes items goods such as clothing, heirlooms, jewelry and accessories. Household goods include home furnishings (e.g., furniture, rugs, and decorations) and recreational items (e.g.,

televisions, table or digital games, musical instruments and equipment). Such items are generally excluded. However, any single item with an equity value in excess of \$1,000 may be evaluated for treatment as a resource.

#### **D. Liquid Resources**

Liquid resources typically take the form of personal property, though there are exceptions. In general, the availability of a liquid asset determines whether it is a countable resource. Resources are available if the owner has both the legal authority and actual ability to use them or to convert them to cash. Liquid resources are presumed to be available. At the time of Medicaid eligibility renewal, a beneficiary must notify the EOHHS if there has been any change in the availability of a resource.

- (1) **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 applicant/beneficiary and members of the FRU for deeming purposes. In instances in which an account is jointly held, the value is apportioned equally among owners unless there is a title or deed to the contrary. In cases in which there is ownership in common or in entirety, the provisions in Section 1410.01 (C)(4).
- (2) **Investments** – Stocks, bonds, mutual funds and other investment instruments are evaluated in terms of sole or joint ownership in the same manner as cash and then as follows:
  - 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.
  - Bonds and Securities. The cash value of bonds/securities is the bid price. The bid price is a countable resource unless it was not paid for in full at the time of purchase – i.e., bought on the margin. Any debt owed is deducted from the value when calculating the amount of the resource that is countable.
  - Stocks. The value of a stock is the closing price if it is publicly traded. The value of stocks is a countable resource.
- (3) **Life Insurance** – Life insurance is a contract between a person who pays premiums on a regular basis and an insurer who agrees to pay a specific sum to a designated beneficiary upon the death of the insured. Treatment of life insurance depends on the type (whole v. term and face v. cash value) as follows:
  - Community Medicaid – EAD. If the combined face value of the whole life insurance policies owned by any member of the FRU does not exceed \$1,500, then the cash surrender value is excluded. Owned, for these purposes, means the policyholder. If the total face value exceeds \$1,500, the cash value of the policy,

excluding any amounts up to \$1,500, and all dividend additions are considered a countable resource. Life insurance owned by persons outside the FRU is not considered even if a member is the insured.

- Community Medicaid – Medically Needy. For purposes of medically needy eligibility, the face value cap for life insurance is \$4,000. If the total face value is above that amount, the cash value of the policy less the \$4,000 is a countable resource.
- Term life insurance. This form of life insurance is not countable as a resource, no matter what its face value.

(4) **Annuities** – This category includes IRAs, KEOGHs, and other work-related pension plans. For Community Medicaid, funds in such accounts are excluded, including from the deeming process, for non-applicant members of the FRU. Otherwise, the State considers whether the annuity is a liquid resource, ownership and beneficiaries and if it is the accumulation (pay-in) or annuitization (pay-out) phase. 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 cash-in an annuity is deducted from the amount of the payout. Treatment of annuities for Community Medicaid eligibility purposes is as follows:

- (a) 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 for purposes of Medicaid eligibility when an applicant/beneficiary is the owner. An annuity is presumed to be revocable when the annuity contract is silent on revocability.
- (b) Annuity owned by someone other than the applicant or spouse. An annuity is an unavailable resource for purposes of Medicaid eligibility when the owner of the annuity is not the applicant or the spouse of the applicant or either has abandoned all rights of ownership. However, if payments from the annuity are being made to the individual (or spouse), those payments may be counted as income to the applicant/beneficiary (or spouse) and considered for both income eligibility and deeming purposes.
- (c) Treatment by Phase. An annuity in its accumulation phase is considered a countable resource of an applicant who is the owner because it can be liquidated for a lump sum or sold. An annuity in its pay-out phase is only considered an excluded resource if the applicant only has the right to liquidate the annuity for the present value of all future payments and this commuted value that is less the its equity value.

(5) **Promissory Notes and Mortgages** – The current resource value of a promissory note or property agreement such as a mortgage is its outstanding principal balance, unless the applicant provides proof of:

- A legal bar to the sale of the promissory note; or

- An estimate from a knowledgeable source (bank or commercial credit institution, etc.) demonstrating the market value of the promissory note is less than its outstanding principal balance.

The outstanding principal balance is the balance in the month for which the determination is being made. An amortization schedule can be used to determine the outstanding principal balance and the interest income if the terms of the agreement are known.

- (6) **Trusts** – In general, the treatment of trusts depends on the specific type and whether they are revocable or irrevocable by the grantor – i.e., the person who established the trust. For LTSS eligibility purposes, the evaluation of trusts focuses in greater depth to consider whether there have been any impermissible transfers. Section 1508 identifies the types of trusts and how they are treated. For Community Medicaid purposes, the following rules apply:
- (a) Revocable trusts. If the trust can be revoked by the grantor under RI law, the principal and interest are treated as a resource.
  - (b) Irrevocable trusts. If the trust cannot be revoked by the grantor – portions of principal that could be paid to the beneficiary are a countable resource.

## **Section 1412.01 Resource Deeming**

### **A. Scope and Purpose**

Resource deeming applies only to IHCC Community Medicaid and Medically Needy applicants.

### **B. Definitions**

For the purposes of this rule, the definitions for deeming of income in Section 1405.02 apply.

### **C. Deeming Rules**

Only the resources of the applicant's spouse or the parent(s) of a child are considered for purposes of deeming resources. The deeming process proceeds as follows:

- (1) **Spouse to spouse deeming** – In deeming resources from one spouse to the other, only the resources of the couple are considered. When an applicant and 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 for Medicaid or a non-applicant.

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 deeming** – In deeming resources from a parent to a child, only the resources of the parent are considered. 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).
- 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 for in their own right. Only one home and one automobile are excluded.
  - It does not matter whether the parent(s) is or is not eligible for Medicaid.
  - 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.
  - When there is more than one applicant/eligible child, the resources available for deeming are shared equally among the eligible children.
  - None of the parents' resources are deemed to any other non-applicant/ineligible children.

A child is not eligible for Medicaid as Medically Needy 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 – a Medicaid Eligibility group of one – of \$4,000.

**Section 1412.02 Excluded Resource Summary**

<b>Excluded Resources: IHCC Groups – Community Medicaid</b>	
The home and adjoining land	
Household goods and personal effects that have a value of \$5,000 or less	Payments or benefits paid under other federal statutes
Once vehicle	Disaster Relief Assistance
Property of a trade or business that is essential for self-support	Burial space of any kind and any pre-paid burial funds up to \$1,500
Non-Business property essential for self-support	SSI or SSDI retroactive payments for a six months
Resources of beneficiary necessary to fulfill and approved PASS	Housing assistance provide through a federal, state or local program
Life insurance – Whole term if the face value	Earned Income Tax Credit

<b>Excluded Resources: IHCC Groups – Community Medicaid</b>	
for a person does not exceed \$1,500	
One year of victim’s compensation funds provided through a federal, state or local program	One year of reallocation assistance provided through a federal, state or local program

**Section 1415 Community Medicaid –Medically Needy Flexible Test of Income**

**A. Scope and Purposes**

For members of the Community Medicaid IHCC groups and children up to age 19, who have income that exceeds the income standard for their coverage group and have high health care expenses, a six-month spenddown is a route to Medicaid “Medically Needy” eligibility. The six-month spenddown amount is the difference between the beneficiary’s net income for a six-month period and the applicable Federal Poverty Level (FPL) for a six-month period. This spenddown amount is for the entire six-month eligibility period. In a limited number of circumstances, members in the same household may have different spenddown amounts, depending on the net income and the FPL standard used to determine that member’s eligibility.

**B. Process for Determining Flex Eligibility**

Applicants for Medically Needy eligibility under the provisions of this section must meet all other eligibility requirements for their specific coverage group. There are no additional general requirements for the use of a six-month spenddown.

- (1) **Timelines** – Applicants must meet the spenddown amount by the end of the application month or the date the application is processed, whichever is later, for allowable health care expenses.
- (2) **Excluded Expenses** – Health care expenses that are subject to payment by any other third party payer are not considered the liability of the applicant and are not deducted from the excess income.
- (3) **Continuing Eligibility** –After the beneficiary meets the six-month spenddown amount, eligibility continues for the remaining portion of the six-month eligibility period, provided there are no changes that adversely impact eligibility.

**C. Spenddown Calculation**

For beneficiaries whose income exceeds the standard for their eligibility coverage group, the spenddown standard for their eligibility coverage group is applied. For example, the appropriate spenddown standard for parents/caretakers is 133% of the FPL and 261% of the FPL for children

and pregnant women. The appropriate spenddown standard for EAD beneficiaries is the medically needy income limit adjusted for household size.

(1) **Spenddown Amount** – The spenddown amount is calculated as follows:

- The beneficiary’s anticipated monthly net income for each month of the eligibility period based on the appropriate EAD eligibility criteria.
- Net income for all six (6) months.
- Eligibility is determined using the appropriate standard for the applicant’s eligibility coverage group.

(2) **FPL Comparison** – The applicable six-month FPL standard is subtracted from the beneficiary’s six-month net income. If the result is:

- 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.
- Greater than the FPL standard continue, further calculations are required.

(4) **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.

(5) **Application of Allowable Expenses** – Allowed health care expenses are to the six-month spenddown amount. If the applicant will incur bills to satisfy the spenddown after the date the application is processed, the final processing will be delayed until after the applicant has received the health care services. Pre-approval of certain remedial (Medicaid LTSS) services is required if the MN beneficiary does not qualify for a preventive level of care.

#### **D. Six-Month Spenddown Renewal**

Upon renewal, a six-month spenddown is calculated in the same manner.

#### **E. Allowable Expenses**

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 can be:

- Paid or unpaid health care bills incurred in the current eligibility period; and
- Unpaid bills incurred prior to the current eligibility period.

The portion of a bill used to meet a previous spenddown cannot be used again in future spenddown calculations, unless the entire eligibility period was denied.

(1) **Allowable health care expenses** – Such expense include, but are not limited to:

- Physician /health care provider visits
- Health insurance premiums, co-pays and deductibles
- Dental visits
- Chiropractic visits
- Co-payments
- Prescription drugs
- Tests and X-rays
- Hospital and nursing care
- Home nursing care, such as personal care attendants, private duty nursing and home health aides
- Eyeglasses
- Hearing aids
- Dentures
- Medical supplies, such as wheelchairs
- Therapy, such as speech, physical, or occupational therapy
- Transportation for medical care, such as car, taxi, bus or ambulance

(2) **LTSS (remedial care) expenses** – Costs related to LTSS level or remedial care, such as home nursing care/homemaker services, adult day and home stabilization may be applied to a spenddown when a beneficiary meets the LTSS preventive level of need. In all other instances, Community Medicaid MN beneficiaries must obtain per-authorization from an agency eligibility specialist to count these costs toward a spenddown.

## **F. Expense Exceptions.**

Certain health care expenses are *not* allowed to be deducted from excess income. Such expenses include, but are not limited to:

- Premiums paid by Medicaid or paid by a Medicare Savings Program (MSP) as a health care expense
- 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.

## **Section 1420. Retroactive Coverage**

### **A. Scope and Applicability**

Medicaid coverage may start retroactively for up to three (3) months prior to the month of application for IHCC group members and certain beneficiaries who are eligible on the basis of other federally-funded programs. To qualify, an applicant must have been eligible during the retroactive period had he or she applied then. 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 individuals and families in the Medicaid Affordable Care Coverage (MACC) Groups identified in MCAR, Chapter 1300, except when a person who is ineligible for coverage in one of these groups applies for Medically Needy IHCC in accordance with the provisions in Section 1415.

## B. Scope and Limits of Coverage

Medicaid beneficiaries in the IHCC groups may request retroactive eligibility for up to three (3) 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.

(c) The following chart details beneficiaries eligible retroactive benefits:

<b>Persons Eligible</b>	<b>Eligible For Retro</b>
IV-E and non IV-E Foster Children	Y
Adoption Subsidy Children Coverage Groups	Y
IHCC group members	Y
Non-citizens who are eligible for emergency Medicaid	Y
LTSS beneficiaries	Y

At the time of application for Medicaid, if the applicant in one of these 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 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 and at the time the service was provided.

(c) 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 period.

All services are subject to the same Title XIX utilization review standards as all other medical services of the Medicaid Program.

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