

0342 Medicaid Coverage for Children and Families

0342.01 Applicability

October 2013

The provisions in this section do not apply to the individuals and families in the Medicaid affordable coverage groups identified in MCAR section 1301 that take effect on January 1, 2014. The rule governing the application process for the Medicaid affordable coverage groups included in section 1301 are located in MCAR section 1303; eligibility requirements for Medicaid-eligible individuals and families in these groups are set forth in MCAR section 1305. Accordingly, the provisions of this section, MCAR 0342, are applicable and in-effect on and after January 1, 2014 only to the extent indicated in each subsection.

0342.05 RI Works Program Families and Section 1931

REV: October 2013

RI WORKS PROGRAM (RIWorks)

In Rhode Island, eligible families receive temporary cash assistance through the RI Works Program (RIW). Medicaid benefits for RIWorks eligible families will be determined through a separate determination of eligibility for Title XIX, Section 1931 coverage in accordance with all of the rules and regulations of the Medicaid Program. Effective January 1, 2014, eligibility for RIWorks participants will be governed by the provisions set forth in the Medicaid Code of Administrative Rules (MCAR) sections 1301.03.01 (01) pertaining to families covered through Section 1931 of Title XIX of the U.S. Social Security Act – the federal Medicaid law. Any families receiving coverage on January 1, 2014 who were initially determined eligible under section 0342.05 will be subject to the provisions applicable to the Medicaid Affordable Care Coverage (MACC) group for families at the time of their next redetermination in 2015 or if there is a change in eligibility status for any reason prior to the redetermination date. Such redeterminations will entail use of the web-based eligibility system (MCAR section 1301 and 1303), including evaluating income eligibility based on the modified adjusted gross income standard (MAGI) in MCAR section 1307.

0342.25 Pregnant Women

REV: October 2013

Effective January 1, 2014, Medicaid eligibility for pregnant women is governed by the provisions set forth in the Medicaid Code of Administrative Rules (MCAR) section 1301.03.01 (2). Eligibility requirements are set forth in MCAR section 1305. Any pregnant women receiving coverage on January 1, 2014 who were initially determined eligible under this section will be subject to the provisions applicable to the Medicaid Affordable Care Coverage (MACC) group for pregnant women if there is a change in eligibility status for any reason prior to the redetermination date. Such redeterminations will entail use of the web-based eligibility system (MCAR section 1301 and 1303), including evaluating income eligibility based on the modified adjusted gross income standard (MAGI) in MCAR section 1307.

0342.40 Newborn Child of Medicaid Eligible Mother

REV: October 2013

Effective January 1, 2014, Medicaid eligibility for newborn children of Medicaid-eligible pregnant women is governed by the provisions set forth in the Medicaid Code of Administrative Rules (MCAR) section 1305.14 and below as indicated.

0342.40.10.05 Hospital Record of Birth

REV: October 2013

Certain in-state hospitals with maternity units have agreed to assist the Medicaid agency in establishing eligibility for newborns (for Medicaid Only, or RIW/Medicaid) by completing a hospital birth record form. The hospital record of birth contains:

- Newborn's name, date of birth and sex;
- Mother's name; and,
- Information regarding whether the child was discharged in the mother's care.

The document must bear the original signature of the hospital's representative authorized to sign the hospital record of birth.

The authorized representative must be an individual designated as keeper of the facility's official records.

The original of the hospital birth record is given to the mother at the point of discharge from the hospital, and a copy is attached to the hospital bill for the newborn that is sent to the Medicaid agency.

This document is reliable alternate evidence of:

- The age of the child;
- The relationship of the child to the mother; and
- The U.S. citizenship of the child.

The birth record serves as initial documentation for the field staff to add a child to the cash assistance and/or Medicaid case.

Note: This document does not establish paternity for a child born out of wedlock. Paternity for eligibility determination purposes is established only when an adjudication is made by Family Court, or when the official birth certificate issued by the Division of Vital Statistics lists the father's name.

0342.50 Extended Medicaid

REV: October 2013

The Family Support Act of 1988 created a special Medicaid program for families in which parents are making the transition from welfare to work. The program was established because of an

extraordinary lack of health insurance coverage among employed former welfare beneficiaries. These families are most likely to be uninsured and least able to pay out-of-pocket for medical services. Continuing categorically needy Medicaid for up to 12 months provides a greater period of health care protection to families with newly employed parents.

Under welfare reform, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) severed the historical link between eligibility for cash assistance -- formerly called Aid to Families with Dependent Children (AFDC) -- and automatic Medicaid eligibility. However, Congress also created a new Medicaid eligibility category referred to as Section 1931 families.

Extended Medicaid may be accessed directly from Section 1931 eligibility.

Families who are eligible for cash assistance and who choose to forgo cash benefits for whatever reason, remain eligible for Medicaid under the Section 1931 category. If the family subsequently loses eligibility for reasons related to employment, family members may qualify for extended Medicaid.

0342.50.05 Extending Medicaid Section 1931 Medicaid Ends

REV: October 2013

Extended Medicaid may be provided to families for up to twelve (12) months following the loss of eligibility for medical coverage provided for families who receive Section 1931 families Medicaid. Loss of eligibility under Section 1931 because of events related to employment may result in continuing categorically needy Medicaid coverage.

Medicaid eligibility may continue under certain circumstances if a Section 1931 Medicaid case is closed because of increased earned income due to:

- employment; or
- increased hours from employment; or
- an increase in wages.

0342.50.10 Initial Criteria for Extending Medicaid

REV: October 2013

At the time a family becomes ineligible for Section 1931 Medicaid benefits, the Medicaid agency must verify and confirm, whether:

- the family has a child living in the home who is under the age of eighteen (18) or between the age of eighteen (18) and nineteen (19) if the child is a full-time student in a secondary school, or at the equivalent level of vocational or technical training, and is reasonably expected to complete the program before or in the month of his/her nineteenth (19th) birthday. A student attending summer school full time, as defined by school authorities, is considered a full-time student for these purposes; and
- eligibility for Section 1931 Medicaid coverage was discontinued because of earned income of a caretaker relative or other member of the family due to:

- employment;
- increased hours of employment; or
- an increase in wages.

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

Families who meet this initial criteria are eligible to receive Medicaid beyond the loss of health coverage provided to those families receiving Section 1931 Medicaid provided they continue to meet the additional requirements set forth below.

0342.50.15 Additional Requirements

REV: October 2013

When earned income contributes to the loss of eligibility for Section 1931 Medicaid, a notice is sent informing the family of the right to continue to receive medical coverage under extended Medicaid for up to the maximum of 12 months allowable under the program, and of the requirements to:

- submit a report which includes an accounting of the family's earned income and the "necessary child care" expenses;
- enroll in an employer's health plan (whether individual or family coverage) if it is offered at no cost to the caretaker relative; and
- report circumstances which could result in the discontinuance of extended benefits (e.g., no age appropriate child in the family or a move out-of-state).

0342.50.20 Loss of Benefits Due to Employment

REV: October 2013

A required element for eligibility to receive extended Medicaid is employment of a caretaker relative or other member(s) of the family whose earned income contributes to the family's loss of eligibility for Section 1931 Medicaid.

Often employment linked with other changes, such as a parent returning to the home or a child turning eighteen, may combine to cause the loss of eligibility. While there must be a relationship between earned income and the loss of eligibility for Section 1931 Medicaid to qualify for extended Medicaid, the advent or increase in earned income need not be the only factor causing the loss.

0342.50.25 Individuals Eligible to be Included

REV: October 2013

The first month of extended Medicaid is the first full or partial month in which the family loses the medical coverage received after the loss of their Section 1931 Medicaid coverage. Extended Medicaid is provided to those individuals:

- who are living in the household, and whose needs and income were included in determining Section 1931 eligibility of the assistance unit at the time such benefits were discontinued;
- whose needs and income would be taken into account in determining Section 1931 Medicaid eligibility of the assistance unit if the family were applying for either of these programs in the current month.

Under the above definition, a child born after Section 1931 benefits are discontinued, or a child, parent or step-parent who returns home after Section 1931 benefits are discontinued, is included as a member of the family for purposes of providing extended Medicaid.

0342.50.30 Initial Receipt of Extended Medicaid

REV: October 2013

Extended Medicaid continues throughout the first seven months following the loss of Section 1931 Medicaid eligibility unless:

- no age-appropriate child is living in the family; or
- the caretaker relative refuses to apply for health coverage offered by the employer.

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

The Medicaid program requires recipients to utilize all resources available to them to pay for all or part of their medical care before using Medicaid. If the caretaker relative fails to avail her/himself of an employment related health plan (either individual or family membership) that is approved for RIte Share purposes, extended benefits must be discontinued.

0342.50.35 Continuing Receipt of Extended Medicaid

REV: October 2013

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

- include a child who meets the age requirement living in the household; and
- timely file the earned income report when due in the seventh (7th) month; and
- pass the 185% FPL earned income test; and
- pass the caretaker relative employment test.

Additionally, an employed caretaker relative must enroll in an employment-related health plan, if such plan is offered.

0342.50.40 Earned Income Report - Requirement

REV: October 2013

During the period of extended Medicaid, the family is required to file one (1) report due in the seventh (7th) month of extended Medicaid.

The report is filed in the seventh month of extended Medicaid coverage and is an accounting of the family's total earnings and necessary child care expenses incurred during month six (6) of extended Medicaid.

The following information is reported.

- the family's gross monthly earnings received in the specified month, including the earnings of any individual who is eligible to be included in the coverage, but who may not be included in the coverage because of a statutory exclusion (e.g., an individual who fails to comply with child support requirements); and
- the necessary child care expenses for the specified month.

Necessary child care is defined as the child care expenses which allow a caretaker relative to be employed.

0342.50.40.10 Family's Total Gross Earnings Defined

REV: October 2013

The total gross earned income of family receiving extended Medicaid is defined as the total countable earned income of all the members of the family without the application of any earned income disregards.

0342.50.40.15 Necessary Child Care Expenses Defined

REV: October 2013

For an extended Medicaid family, necessary child care expense is defined as a reasonable child care expense necessary for the employment of a caretaker relative.

'Reasonable' refers to a child of an age or of a dependency plausibly needing child care. Additionally, child care expenses paid by the Medicaid agency or another third-party are not recognized as an allowable deduction. A necessary child care expense can be incurred, it need not be paid.

0342.50.45 Submitting the Earned Income Report

REV: October 2013

The extended Medicaid earned income reports are:

- an accounting of the family's total gross earned income and a caretaker relative's necessary child care expenses for month six (6) of extended benefits;
- due by the 5th day of month seven (7) respectively of extended benefits.

On the 15th of each month, a reporting form is sent to any family who has reached month six (6) of extended Medicaid. Such a family must report the required income and necessary child care information by the 5th day of the following month.

On the 7th day of each month, a reminder notice is sent to all extended Medicaid cases scheduled to report in the month. This is to encourage compliance by any family that has neglected to return the report by the due date (5th of the month). Instructions direct those who have complied to disregard the reminder notice.

All reports due in the month must be received by the Medicaid agency prior to the close of business on the 21st day of the month. Medicaid is discontinued on the last day of the month for any family who fails to submit the report by the 21st of the month.

0342.50.45.05 Employment Test for the Caretaker Relative

REV: October 2013

For families to remain eligible beyond the seventh (7th) month of extended benefits, a caretaker relative must meet an employment test. Unless there is good cause, a caretaker relative must be employed. The caretaker relative must claim good cause on the income report form in order to have the circumstances of a lack of employment considered. (See Section 0342.50.60.10 for Good Cause.)

A caretaker relative must have earnings under the employment test even if the loss of benefits from Section 1931 Medicaid was caused by the earnings of another family member.

If a caretaker relative fails the employment test without good cause, extended Medicaid benefits are discontinued on the last day of the seventh (7th) month of extended Medicaid. InRhodes generates a notice of discontinuance to the recipient.

0342.50.50 Failure to Meet Requirements

REV: October 2013

If the family fails to pass the income test, the Medicaid agency discontinues extended Medicaid benefits on the last day of a reporting month. In addition failure to pass the employment and income tests in month seven (7) of extended benefits, eligibility will end in any month during extended Medicaid when it is determined that:

- the family ceases to include a child who meets the age requirement living in the household; or
- an employed caretaker relative failed to enroll in a employment-related health plan.

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

0342.50.60 Good Cause

REV: October 2013

A family may have reason to claim good cause for failure to comply with required action.

- Good cause may exist for a failure to timely submit an earned income report;
- Good cause may exist for a failure of the caretaker relative to be employed.

Good cause may not be claimed for failure to comply with any extended Medicaid requirements other than the above.

0342.50.60.05 Failure to Submit Earned Income Report

REV: October 2013

Good cause for failure to submit the earned income report or to include appropriate verifications, may exist if circumstances beyond the recipient's control prevent the requirement from being met when due. Circumstances in which good cause may exist include, but are not limited to, the following:

- hospitalization or documented serious illness of the recipient or a member of the recipient's family;
- lost or stolen mail confirmed by the U.S. Postal Service;
- a catastrophe caused by fire, flood, or a severe weather condition.

0342.50.60.10 Caretaker Relative Failure to be Employed

REV: October 2013

The caretaker relative may have good cause for lack of employment if loss of employment was caused by illness or other factors beyond the caretaker relative's control. Extended Medicaid may continue if the caretaker relative can show good cause for being unemployed. Good cause includes circumstances beyond the recipient's control, such as, but not limited to:

- involuntary loss of employment;
- illness or incapacity;
- unanticipated household emergency;
- work demands or conditions that render continued employment unreasonable, such as working without being paid on schedule.

0342.50.70 Discontinuing Extended MA - Notice Required

REV: October 2013

When a family becomes ineligible for Section 1931 Medicaid for reasons related to employment, the family is advised in writing of their continuing eligibility for medical coverage. The Medicaid agency

must provide timely notice informing the family of the extended Medicaid program's eligibility requirements; the time-limited nature of the program (12 months maximum), and the exact date coverage will end when the maximum period of benefits has passed. The notice also explains that family members may qualify for Medicaid under other provisions of the program when eligibility for extended Medicaid ceases.

When extended Medicaid is discontinued for any reason prior to the end of the maximum twelve-month period, a separate notice of adverse action is sent.

0342.70 Adoption Subsidy/IV-E Foster Child

REV: October 2013

This coverage group includes foster children, children in kinship guardianship care and adopted children whose Medicaid eligibility is based on eligibility for the Title IV-E Foster Care Maintenance Program, Kinship Guardianship Assistance Program or Adoption Assistance Program (InRHODES Category Code 54).

The Foster Care Maintenance Program provides federally funded foster care payments on behalf of the following children:

- Children previously eligible under the Title IV-A Foster Care Maintenance Program;
- Certain children voluntarily placed or involuntarily removed from their homes;
- Children in public non-detention type facilities housing no more than 25 children.

Children for whom a cash payment is made under the foster care program are deemed eligible for Medicaid. Medicaid eligibility for children in the Foster Care Maintenance program exists as long as the Title IV-E payment continues to be made for them or up to age twenty-six if still in foster care age eighteen (18).

The Adoption Assistance Program provides Federal funding for continuing payments for hard to place children with special needs. The special needs adoptive children must be SSI-recipients at the time of adoption. A cash payment is not a Medicaid eligibility requirement for Title IV adoption assistance children. These children continue to be eligible for Medicaid as long as a Title IV-E adoption assistance agreement is in effect. An interlocutory order or final decree need not exist.

0342.70.05.05 Medicaid Eligibility, State of Residence

REV: October 2013

Title IV-E adoption assistance children, kinship guardianship assistance children and Title IV-E foster care children are eligible for Medicaid in their states of residence.

0342.70.05.10 DCYF Certification Responsibility

REV: October 2013

Primary certification responsibility for Title IV-E children resides with the Department of Children, Youth and Families (DCYF).

When a parent or guardian of a IV-E foster child, child in a kinship guardianship care or adopted child, who is now residing in Rhode Island contacts a local district office to apply for Medicaid for his/her child, referral is made to the IV-E Unit at the DCYF.

0342.75 Non IV-E Foster Child Under 18

REV: October 2013

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

0342.80.10 Continuing Responsibility, DCYF

REV: October 2013

DCYF has the continuing responsibility to notify the Medicaid Foster Care Unit of any change in circumstances for the Foster Care, Kinship Guardianship Care or Group Care child. The change in circumstance could be a change in placement or a change in the child's income or resources.

When a child is no longer in the agency's care, DCYF must notify the Medicaid agency of the child's date of closure.

If a child is returned to his family, the agency worker informs the family about Medicaid. If the family is potentially eligible, the worker helps the family apply for Medicaid coverage.

0342.85 Non IV-E, State Sub Adopt Assistance

REV: October 2013

This coverage group is hard-to-place children for whom the state provides adoption/guardianship assistance and who are not eligible for Title IV-E. The basis of eligibility for Medicaid is deprivation of parental support occasioned by the child's separation from his/her family.

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

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

0342.90 Refugee Medical Assistance

REV: October 2013

This coverage group is refugees who have resided in the United States for eight (8) months or less, and who are ineligible for one of the categorical programs due to lack of a characteristic.

To be eligible for Refugee (RMA) Medicaid, a refugee must:

- Meet the refugee immigration and identification requirements or be the dependent child of such refugees;
- Meet the non-financial requirements and conditions of eligibility for Refugee Cash Assistance (RCA). (Receipt of RCA is not an RMA eligibility requirement);

- Not have been denied or terminated from RCA due to voluntary termination from a job or a refusal of employment;
- Not be full-time students except as allowed in Section 0906.20;
- Be recipients of RCA or, for certain refugees prohibited from receiving a cash payment for a limited period of time, be eligible for some form of RCA;
- Have income and resources within the Categorically Needy limits.

0342.90.05 Treatment of Income

REV:07/1994

In-kind services and shelter provided by a sponsor or resettlement agency are not considered as income to the refugee when determining financial eligibility for RMA.

Direct cash payments to the refugee from a sponsor or resettlement agency are counted as unearned income.

0342.90.10 Eight Month Limitation for RMA

REV:07/1994

Receipt of RMA under the characteristic of "refugee" is limited to the first eight (8) months 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 Immigration and Naturalization Service.

0342.90.15 Extended RMA Coverage

REV:07/1994

If a refugee receiving Refugee Cash Assistance becomes ineligible solely due to increased earnings from employment, the refugee's RMA is extended, at the same level of care, for four months or until the end of the eight month limitation, whichever comes first.

0342.90.20 Termination of Eligibility for RMA

REV:07/1994

A refugee who is terminated from RCA because of failure or refusal to participate in the employment-related requirements (Sections 0906.10 and 0906.20) is also terminated from RMA. The RMA termination applies only to the sanctioned individual.

0342.95 Closed Family-Related MA-HMO Enroll

REV:01/2002

This coverage group is individuals who would be ineligible if not enrolled in an HMO. These individuals are closed family-related recipients locked in for the enrollment period by managed care.

0342.96 Post Foster Care Coverage Group

REV: October 2013

The Foster Care Independence Act of 1999 established the John H. Chafee Foster Care Independence Program. Participants in this Medicaid coverage group consist of children who are at least eighteen (18) years old but are not yet twenty-six (26) years old and who meet the following criteria:

1. They were in foster care under the responsibility of the Department of Children, Youth and Families (DCYF) on their eighteenth (18th) birthday, and
2. They have been closed to foster care services from DCYF; and
3. They are residents of Rhode Island.

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

A redetermination must be completed once in a twelve (12) month period to ensure that the post foster care adolescent is a resident of Rhode Island. If the child establishes residency in another state, s/he would not be eligible for medical coverage through the State of Rhode Island.

0342.96.05 Continuing Responsibility, DCYF

REV: October 2013

DCYF has the continuing responsibility to notify the Medicaid Foster Care Unit of any change in circumstances for the Independent Foster Care Adolescent which might cause him/her to be ineligible based on the above criteria.