STATE OF RHODE ISLAND

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVCES

Statement of Need for Emergency Filing

MEDICAID CODE OF ADMINISTRATIVE RULES

SECTION 0372: SPECIAL TREATMENT COVERAGE GROUPS

The Executive Office of Health & Human Services (EOHHS) is filing this "emergency" amendment to rule #0372 "Special Treatment Coverage Groups" in order to incorporate recent changes related to the Medicare Part "B" premiums effective January 1, 2016.

Section 0372.05 (A)(2)(c) has been amended to clarify that for persons enrolled in Part B on or before December 31, 2015, the premium will remain at $104.90/month. For persons enrolling in Part B for the first time on and after January 1, 2016, the premium will be $121.80/month.

Because the revised standards were published by CMS on November 20, 2015 and must take effect on January 1, 2016, EOHHS is filing on an "emergency" basis to accommodate this compressed time line. Additionally, the State is adopting these amended rules to set forth these provisions in a timely manner in order to prevent wrongful denial, discontinuance, or interruption of benefits for Medicaid applicants and beneficiaries. These rules will be posted for public review and comment shortly.

0372 Special Treatment Coverage Groups

0372.05 Medicare Premium Payment Program (MPPP)

REV: January 2016

Purpose: The Medicare Premium Payment Program helps 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. Low income adults with disabilities who have Medicare coverage, may be eligible for the Medicare Premium Payment Program (MPPP). 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 resource determine which type of Medicare premium assistance is available.

A. Medicare is the federal health insurance to which individuals who are insured under the Social Security system are entitled once they attain 65 years of age or reach the 25th month of a permanent and total disability. Medicare is also available to individuals who have permanent kidney failure and individuals who received a kidney transplant. Medicare has two parts:

Part A Medicare Insurance

a. Pays for hospital services and limited skilled nursing facility services;

b. Is available without charge to individuals who are insured under Social Security or Railroad Retirement systems and who have attained 65 years of age or have reached the 25th month of a permanent and total disability;

c. Is available without charge to certain individuals who receive continuing dialysis for permanent kidney failure and certain individuals who have had a kidney transplant;

d. Is also available to aged or disabled individuals who are not insured under the Social Security System for a premium amount determined by the Social Security Administration.

Part B Medicare Insurance

a. Pays for physician services, durable medical equipment and other outpatient services;

b. Is available to both "insured" and "uninsured" individuals who have attained 65 years of age or have reached the 25th month of a permanent and total disability upon payment of a monthly premium.

c. The Part B premium as of January 1, 2015 is $104.90/month for timely enrollees. For persons enrolled in Part B on or before December 31, 2015, the premium will remain $104.90/month. For persons enrolling in Part B for the first time on and after January 1, 2016, the premium will be $121.80/month.

B. Enrollment

1. Individuals who receive Social Security or Railroad Retirement benefit payments are automatically enrolled in Medicare when they turn 65 or reach their 25th month of disability.

2. Individuals who need to apply for enrollment in Medicare include those who:

   a. Have not applied for Social Security or Railroad Retirement Benefits
   b. Were involved in certain government employment
   c. Have kidney failure/kidney transplant.

3. The initial enrollment period is a seven-month period that starts three (3) months before the individual first meets the requirements for Medicare. Individuals who do not enroll in the initial enrollment period may enroll in the general enrollment period, held each year from January 1 through March 31.

C. In accordance with federal law, limited Medicaid is provided to low-income Medicare beneficiaries. This limited coverage helps eligible individuals pay for some or all of their out-of-pocket Medicare expenses. There are four (4) categories of Medicare Premium Payment Program Benefits:

1. Qualified Medicare Beneficiary (QMB)
2. Specified Low Income Medicare Beneficiary (SLMB)
3. Qualifying Individual-1 (QI-1)
4. Qualified Disabled Working Individual (QDWI)

0372.05.05 Qualified Medicare Beneficiary (QMB)

REV: June 2015

A. QMBs were established under the legal authority of the Medicare Catastrophic Coverage Act (MCCA) of 1988. States are required to pay Medicare Part A and Part B premiums, deductibles, and co-payments on behalf of eligible individuals. 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 Medicaid Program allowed amount(s) for the service(s).

An individual may qualify for and receive QMB and full Medicaid at the same time.

1. A Qualified Medicare Beneficiary (QMB) is an individual or member of a couple who:

   a. Is enrolled in or entitled to Medicare Part A;

   b. Has countable resources of $7,280 for an individual or $10,930 for a couple;

   c. Has countable income less than or equal to one hundred (100%) percent of the Federal Poverty (FPL) Guidelines; and

   d. Meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medicaid Program.

2. Under this coverage group:

   a. Individuals cannot be reimbursed directly by Medicaid;

   b. Eligibility begins on the first day of the month after the application is filed and all eligibility requirements are met. There is no provision for retroactive eligibility;

   c. Eligibility is certified for a twelve (12) month period;

   d. Countable income is determined using SSI related methodology (Medicaid Code of Administrative Rules (MCAR) Sections 0356 and 0364);

   e. Income limits are rigid. There is no flexible test of income; and

   f. Cost-of-living increases in Title II benefits (COLAs), effective in January each year are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty (FPL) Guidelines update is published.

0372.05.10 Specified Low Income Medicare Beneficiary (SLMB)

REV: June 2015

A. SLMBs were established under the legal authority of the Omnibus Budget Reconciliation Act (OBRA) of 1990. States are required to pay the Medicare Part B premium on behalf of eligible individuals.

Medicaid makes a direct payment to the federal government for the Medicare Part B premium for an eligible SLMB. An individual may qualify for and receive SLMB and full Medicaid at the same time.

1. A Specified Low-Income Medicare Beneficiary (SLMB) is an individual or member of a couple who:

a. Is enrolled in or entitled to Medicare Part A;

b. Has countable resources of $7,280 for an individual or $10,930 for a couple;

c. Has countable income in an amount greater than one hundred (100%) percent of the Federal Poverty (FPL) Guidelines and less than or equal to one hundred twenty (120%) percent of FPL; and

d. Meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medicaid Program.

2. Under this coverage group:

a. Individuals cannot be reimbursed directly by Medicaid;

b. Eligibility begins on the first day of the month in which the application is filed and all eligibility requirements are met;

c. Eligibility is certified for a twelve (12) month period;

d. Retroactive eligibility may be determined and benefits granted for the three months prior to the month of application;

e. Countable income is determined using SSI-related methodology (EOHHS Manual Section 0356 and 0364);

f. Cost-of-living increases in Title II benefits (COLAs) effective in January each year are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty (FPL) Guidelines update is published; and

g. Income limits are rigid. There is no flexible test of income.

0372.05.15 Qualifying Individual-1 (QI-1)

REV: June 2015

A. Qualifying Individuals were established under the legal authority of the Balanced Budget Act (BBA) of 1997. States are required to help pay certain Medicare costs through a capped allocation of funds for Qualifying Individuals-1 (QI-1). Medicaid makes a direct payment to the federal government for the Medicare Part B premium for an eligible QI-1. Qualifying Individuals (QI 1) are not otherwise eligible for Medicaid. QI benefits are subject to federal appropriations.

1. A Qualifying Individual-1(QI-1) is an individual who:

a. Is enrolled in or entitled to Medicare Part A;

b. Has countable income greater than one hundred twenty (120%) percent of the Federal Poverty (FPL) Guidelines and less than one hundred thirty five (135%) of FPL;

c. Has countable resources of $7,280 for an individual or $10,930 for a couple;

d. Meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medicaid Program; and

e. Is not eligible for Medicaid under any other coverage provision.

2. Under this coverage group:

a. The individual cannot be reimbursed directly by Medicaid;

b. Countable income is determined using SSI-related methodology (See EOHHS Manual Sections 0354 and 0362);

c. Cost-of-living increases in Title II benefits (COLAs), effective in January each year, are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty (FPL) Guideline update is published;

d. Eligibility begins the month in which the application is filed and all eligibility requirements are met;

e. Eligibility may be established and benefits granted up to three months prior to application, but not prior to the beginning of the calendar year; and

f. Eligibility is certified until the end of the calendar year in which the application was filed.

0372.05.20 **Qualified Disabled & Working Individuals (QDWI)**
REV: February 2014

A. QDWIs were established under the legal authority of the Omnibus Budget Reconciliation Act (OBRA) of 1989 which allows persons with disabilities who lose or have lost Medicare coverage solely because of work to buy it back. These individuals are called "Disabled Working Individuals." OBRA further requires states to pay the Part A Medicare premium for certain individuals in this group, called “Qualified Disabled Working Individuals.” The single benefit of this coverage is Medicaid payment of the Medicare Part A premium. Qualified Disabled Working Individuals (QDWIs) are not otherwise eligible for Medicaid.

1. A Qualified Disabled and Working Individual (QDWI) is an individual who:

a. Is entitled and able to enroll, as determined by the Social Security Administration, in Medicare Part A as a disabled working individual;

b. Lost original entitlement to Medicare Part A through the loss of Title II benefits due to substantial gainful activity;

c. Has countable income of less than or equal to 200% of the Federal Poverty Level;

d. Has countable resources within twice the SSI limit;

e. Meets the citizenship/immigration, residency, enumeration, and third party resource requirements of the Medicaid Program; and

f. Is NOT eligible for Medicaid under any other coverage provision.

2. Under this coverage group:

a. Medicaid makes a direct payment to the federal government for Part A Medicare premiums. An individual cannot be reimbursed directly by Medicaid;

b. Eligibility begins the month in which the application is filed and all eligibility requirements, including enrollment in Medicare Part A, are met;

c. Eligibility may be determined and benefits granted for up to three (3) months prior to the month of application;

e. Countable income and resources are determined using SSI-related methodology (See MCAR Sections 0356 and 0364);

f. Income limits are rigid. There is no flexible test of income.

0372.05.25 Eligibility Determination

REV: 09/2010

A. To qualify for MPPP eligibility, an individual must meet the non-financial requirements of citizenship, alienage, residency, enumeration and third party resource requirements that all other Medicaid applicants must meet, as well as the specific requirements of the Medicare Premium Payment Program: Enrollment in Medicare Part A, income and resources limits.

B. An individual or member of a couple may qualify for Medicare Premium Payment Program benefits regardless of living arrangement. Income and resource limits are uniform, and do not vary depending on living arrangement or institutional status.

C. An individual may apply for the Medicare Premium Payment Program only, Medicaid only, or both Medicaid and Medicare Premium Payment Program benefits. If eligible, the applicant is certified at his/her option for:

1. Medicare Premium Payment Program Benefits only;

2. Medicaid only; or

3. Medicaid with QMB/SLMB. (QIs and QDWIs are not eligible for Medicaid.)

D. Notices of agency action to applicants for Medicare Premium Payment Program benefits parallel the notices sent regarding actions on Medicaid applications. Applicants for Medicare Premium Payment Program benefits must receive adequate notice of agency action to accept or reject an application for such coverage.

1. The agency must send timely and adequate notice of benefit termination. The notice must be mailed at least ten (10) days prior to the effective date of the action.

2. Applicants/recipients requesting or receiving Medicare Premium Payment Program benefits are entitled to the same due process protection afforded other Medicaid applicants and recipients.

0372.05.30 Application Process

REV: June 2015

A. There are three distinct application processes for individuals and members of couples who are requesting Medicare Premium Payment Program benefits.

1. The Medicaid agency provides the following two application processes:

a. Combined Application (Form DHS-2) available at:
http://www.eohhs.ri.gov/ReferenceCenter/FormsApplications/MedicaidApplication.aspx

i. Individuals and couples applying for all covered Medicaid benefits complete the DHS-2 ("Application for Assistance") form.

ii. An applicant is entitled to have eligibility determined under any and all Medicaid coverage groups for which the applicant may qualify, including Medicare Premium Payment Program benefits.

iii. Information about the benefits available under each coverage group must be provided to the individual at the time of application.

iv. If an applicant does not voluntarily choose to apply for Medicaid coverage under a specific coverage group, eligibility is determined for all potential coverage groups, as specified.

b. Streamlined Application (Form MPP-1)

i. Individuals and couples applying only for Medicare Premium Payment Program benefits may complete the MPP-1 application form and mail it to the local DHS field office.

The application is available upon request and online at:
http://www.eohhs.ri.gov/ReferenceCenter/FormsApplications/MedicaidApplication.aspx

2. The Social Security Administration (SSA) provides the third application process:

a. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), P.L. 110-275, section 113 states that the SSA must transmit data from the Medicare Part D Low-Income Subsidy (LIS) application, with the consent of the applicant, to the Medicaid agency for purposes of initiating an application for the MPPP.

b. MIPPA requires the Centers for Medicare and Medicaid Services (CMS) to make available to SSA and the States, model applications that can be provided to beneficiaries upon their request. The SSA has provided the CMS-designed model application in ten languages, other than English. If a state receives a model application in any language, it is treated as an application for the MPPP.

c. Upon receiving an application in the form of the LIS data transmission from SSA, the Medicaid agency acts upon it in the same manner, and in accordance with the same deadlines, as if the data were an application submitted directly by the applicant to agency.

i. The Medicaid agency is required to act on this data as an application for MPPP benefits, even if the LIS application was denied by SSA.

ii. The Medicaid agency is required to treat these as applications for the MPPP program even if it is an application not previously seen by staff at the Medicaid agency.

d. A finding of eligibility or ineligibility is made for each application, unless the individual withdraws the application or is deceased.

e. The date of electronic transmission of the LIS application from SSA to the Medicaid agency is the date of the MPPP application.

B. To reduce barriers to eligibility for Medicare Premium Payment Program applicants, required verification is obtained from the individual's Social Security record. The State Verification and Exchange System (SVES) is used whenever possible to verify the applicant's date of birth, residency, social security number, social security income, Medicare Claim Number and Medicare Enrollment. Citizenship/ immigration status is pre-determined by the Social Security Administration and that requirement is met with Medicare enrollment. This verification must be obtained before eligibility is approved.

C. Initial eligibility is not delayed while verification of income other than Social Security and resources is pending, providing that the information contained in the application does not conflict with other information provided by the applicant, information contained in other state agency applications, or other documented information known to the Medicaid agency.

D. Income other than Social Security and resources are verified with the applicant's consent by EOHHS. As a condition of continued eligibility, the applicant/ beneficiary must cooperate in the verification process by either: providing verification of income and resources or consent to the Medicaid agency to obtain such verification.

E. Information and/or documentation obtained in the verification process is referred to the appropriate staff for any necessary action.

F. A decision on an application for Medicare Premium Payment Program benefits must be made within thirty (30) days of the receipt of the signed application form in the Medicaid agency office.

1. MPPP application received in the form of the LIS data transmission from SSA does not require a signature.

0372.05.35 Financial Requirements

REV: 09/2010

The resource and income evaluation methods described in Sections 0356 and 0364 for SSI-related individuals are used to determine countable income and resources for Medicare Premium Payment Program applicants.

0372.05.35.05 Resource Limits

REV: June 2015

A. Section 1905(p)(1)(C) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) has been amended to make the resource limit for QMB, SLMB and QI-1s conform to the resource limit for individuals who qualify for the full subsidy Medicare Part D Low-Income Subsidy (LIS), less the disregard for burial funds. The Medicare Part D LIS resource limits are adjusted on January 1 of each year, based upon the change in the annual consumer price index (CPI) since September of the previous year. States must use the new resource limits when determining eligibility for these programs.

1. The basic resource limits for QMB/SLMB/QI-1 status are:
   a. $7,280 for an individual
   b. $10,930 for a couple

2. The resource limit for QDWI, was not changed by MIPPA. The resource limit remains within twice the SSI limit:

   a. $4,000 for an individual
   b. $6,000 for a couple

B. Resource exclusions, including those for life insurance, automobile, tangible personal property/household goods, burial contracts, and funds set aside for burial are identical to those of the SSI program. Refer to MCAR Section 0354.35.

0372.05.35.10 Income Limits

REV: 09/2010

A. The income limits for the Medicare Premium Payment Program benefits, based on the Federal Poverty (FPL) Guidelines for the appropriate family size, are listed below.

1. QMB - less than or equal to one hundred (100%) percent of FPL;

2. SLMB - greater than one hundred (100%) percent FPL and less than or equal to one hundred twenty (120%) percent of FPL;

3. QI-1 - greater than one hundred twenty (120%) FPL and less than one hundred thirty five (135%) percent FPL;

4. QWDI - less than or equal to two hundred (200%) percent of FPL.

0372.05.35.15 Title II COLA Disregard

REV: 09/2010

A. For QMBs, SLMBs, and QI-1s, the cost-of-living increases in Title II benefits (COLAs), effective in January each year, are disregarded in determining income eligibility through the month following the month in which the annual FPL guidance update is published.

B. Only Title II COLAs are disregarded in this manner. This exclusion does not apply to cost-of-living adjustments in other types of income, such as government or private retirement pensions.

0372.10 List & Definitions of Limited Benefit Groups

REV: June 2015

A. The following information describes the various categories of individuals who are entitled to Medicare and eligible for some category of Medicaid limited benefits.

1. Qualified Medicare Beneficiaries (QMBs) - Individuals entitled to Part A of Medicare, with income not exceeding 100% of the Federal poverty level, and resources not exceeding the limit set for the full subsidy Medicare Part D Low-Income Subsidy (currently $7,280 for an individual and $10,930 for a couple). QMBs may be eligible for full Medicaid or may have Medicaid eligibility limited to payment of Medicare Part A and Part B premiums and Medicare cost-sharing (deductibles and coinsurance) for Medicare services provided by Medicare providers.

a. QMBs without other Medicaid (QMB Only) - Individuals entitled to Part A of Medicare, with income not exceeding 100% FPL, and resources not exceeding $7,280 ($10,930 for a couple). Eligibility for Medicaid is limited to payment of Medicare Part A and Part B premiums and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.

b. QMBs with Medicaid (QMB Plus Medicaid) – Individuals entitled to Part A of Medicare, with income not exceeding 100% FPL, and resources not exceeding $7,280 ($10,930 for a couple). Eligibility for Medicaid includes payment of Medicare Part A and Part B premiums and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.

c. Non-QMBs - There are individuals who are eligible for Medicare and Medicaid, but who are not eligible under any of the special Medicare categories. Typically, these are Medicare eligible individuals with income exceeding the limits of any of the special categories who spend down to become eligible for Medicaid. Medicaid benefits are for Medicaid services provided by Medicaid providers, but only to the extent that the Medicaid payment rate exceeds any Medicare payment for the service covered by both Medicare and Medicaid.

2. Specified Low-income Medicare Beneficiaries (SLMBs) - Individuals entitled to Part A of Medicare, with income above 100%, but not exceeding 120% FPL, and resources not exceeding $7,280 ($10,930 for a couple). Eligibility for Medicaid benefits is limited to payment of Medicare Part B premiums.

3. Qualifying Individuals-1 (QI-1s) - Individuals entitled to Part A of Medicare, with income above 120%, but less than 135% FPL, resources not exceeding $7,280 ($10,930 for a couple), and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. The QI-1 program is subject to federal appropriations.

4. Qualified Disabled and Working Individuals (QDWIs) – Individuals entitled to purchase Part A of Medicare (Medicare benefits lost because of return to work), with income below 200% FPL, and resources not exceeding $4,000 ($6,000 for a couple), and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to payment of Medicare Part A premiums.

0372.20 Title XV Coverage Group

REV: February 2014

A. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), amended Title XIX to include an optional Medicaid coverage group for uninsured women 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 found to need treatment for breast or cervical cancer or for precancerous conditions of the breast or cervix. Effective April 2001 and retroactive to January 1, 2001, Medicaid is provided to women who meet the specific eligibility requirements for this coverage group.

0372.20.05 Definitions

REV: June 2015

For purposes of this policy, the following definitions apply:

CREDITABLE COVERAGE means the term as it is defined in section 2701 of the Public Health Service Act, known as the Health Insurance Portability and Accountability Act of 1996, or HIPAA.

Creditable coverage includes, for example, most health insurance coverage (including insurance that may have high deductibles or limits), a group health plan, Medicare, Medicaid, Armed forces insurance, a medical program of the Indian Health Service (IHS) or of a tribal organization, and a state health risk pool.

However, for purposes of this policy, creditable coverage does not include plans which do not provide coverage for the treatment of breast or cervical cancer, or plans which provide only dental, vision, or long term care coverage, or plans which provide coverage only for a specified disease or illness. Further, if a woman is in period of exclusion (such as a pre-existing condition exclusion or an HMO affiliation period) for treatment of breast or cervical cancer or if she has exhausted her lifetime limit on all benefits under her health plan, she is not considered to have creditable coverage for purposes of this policy.

SCREENED FOR BREAST OR CERVICAL CANCER UNDER THE CDC BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM ESTABLISHED UNDER TITLE XV OF THE PUBLIC HEALTH SERVICE ACT means: a. A woman's clinical services were funded all or in part by CDC Title XV funds b. she was screened under the RI Department of Health (HEALTH) Women's Cancer Screening Program (even if their particular clinical service was not paid for by CDC Title XV funds) c. she was screened by a HEALTH designated provider and subsequently enrolled in the HEALTH Women's Cancer Screening Program.

NEED TREATMENT means that the diagnostic test following a breast or cervical cancer screen indicates that the woman is in need of cancer treatment services as verified by the RI Department of Health Women's Cancer Screening Program. These services include diagnostic services that may be necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Based on the licensed health care practitioner’s plan-of-care, women who are determined to require only routine monitoring services for a precancerous condition of the breast or cervix (e.g., breast exams and mammograms) are not considered to need treatment.

COURSE OF TREATMENT means the period of time a woman requires treatment for breast or cervical cancer, or a precancerous condition of the breast or cervix, as specified in writing by the woman's treating licensed health care practitioner.

0372.20.10 Scope of Services

REV: 09/2010

Eligible members of this coverage group receive the full scope of services provided to categorically needy individuals. (Section 0300.20)

0372.20.15 **Eligibility Requirements**

REV: February 2014

A. Under this coverage group, Medicaid is provided to a woman who:

1. Is under age sixty-five (65); and

2. Was screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service (PHS) Act and found to need treatment for either breast or cervical cancer, or a precancerous condition of the breast or cervix; and

3. Does not otherwise have creditable coverage; and

4. Is not otherwise eligible for Medicaid as categorically needy; and

5. Meets the technical Medicaid requirements of residence, citizenship/immigration status, and provision of a Social Security number (Section 0300.25.05) and the cooperation Medicaid requirements relating to provision of information needed for an eligibility determination and assignment of rights to third party payments for medical care (Section 0300.25.15).

0372.20.15.05 No Income or Resource Test

REV: February 2014

A. A woman must meet certain financial criteria in order to qualify for screening under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program and the Rhode Island Department of Health Women's Cancer Screening Program. The Department of Health Women's Cancer Screening Program, or its designees, are responsible for determining eligibility for screening under these programs.

B. However, there are no separate Medicaid Income or Resource Limits for this group.

0372.20.20 Presumptive Eligibility

REV: February 2014

A. Presumptive eligibility is a Title XIX option that permits states to enroll women in Medicaid for a limited period of time before a full application is processed, based on a determination of a qualified entity of likely Medicaid eligibility.

1. This allows early access to health care for women found through screening to need cancer treatment.

2. Presumptive eligibility is granted if, based on information contained on the Medicaid /Title XV Application Form (MA/BCC-1) and information provided by the health care provider conducting the screening, the RI Department of Health (HEALTH) Women's Cancer Screening Program determines that the woman:

    a. Is under age sixty-five (65);

    b. Has no other form of individual or group health insurance (including Medicaid);

    c. Needs treatment for breast or cervical cancer or a precancerous condition of the breast or cervix;

    d. Resides in RI.

3. Presumptive eligibility begins on the date Department of Health determines that the woman appears to meet above criteria.

4. Presumptive eligibility ends on the date a formal determination is made on the woman's application for Medicaid, or if she does not file a Medicaid application, on the last day of the month following the month in which presumptive eligibility begins.

5. The Medicaid agency is responsible for providing the Department of Health Women's Cancer Screening Program with Medicaid application forms and information on how to assist applicants in completing and filing such forms. The Department of Health Women's Cancer Screening Program, or its designees, are responsible for providing the woman with assistance in completing and filing a Medicaid application form (MA/BCC-1). The Department of Health Women's Cancer Screening Program is further responsible for:

    a. Making determinations of presumptive eligibility based on information provided on the MA/BCC-1;

    b. Providing the woman with written notification of presumptive eligibility;

    c. Notifying the Medicaid agency within five (5) days of determinations of presumptive eligibility.

6. If a woman is determined not to be presumptively eligible, the Department of Health Women's Cancer Screening Program provides the applicant with written notification of the following:

a. The reason for the determination;

b. That she may file a formal application for Medicaid and where she may apply for Medicaid;

c. That a formal determination of Medicaid eligibility will be issued by the Medicaid agency based on her completed Medicaid application;

d. If she does not file a Medicaid application, her presumptive eligibility ends on the last day of the month following the month presumptive eligibility began.

7. There are no appeal rights associated with determinations of presumptive eligibility. However, appeal rights do apply to the application for Medicaid.

0372.20.25 Application Process

REV: August 2014

A. The MA/BCC-1, a streamlined mail-in application form, is used to determine eligibility for Medicaid under this coverage group.

1. Verification of immigration status must be provided by the applicant before Medicaid eligibility is established.

a. In addition, verification of the woman's eligibility for screening under the CDC Breast and Cervical Cancer Early Detection Program and her need for treatment is required before Medicaid eligibility is established.

b. However, up-front verification of other information on the application form is not required unless it is inconsistent with that provided on previous Medicaid applications or with other documented information known to the Medicaid agency.

2. Applications for Medicaid are available at the Department of Health Women's Cancer Screening Program, DHS offices, and at other Medicaid-designated locations.

3. The Center for Adult Health is responsible for determinations of Medicaid eligibility for this coverage group. Individuals identified by the Center for Adult Health as potentially eligible for Medicaid under another categorically needy coverage group must cooperate in filing a full Medicaid application (DHS-2 as appropriate) as a condition of maintaining Medicaid eligibility.

4. Eligibility decisions are made in accordance with provisions contained in Section 0302.15. If the applicant indicates that an unpaid medical bill was incurred in the three (3) month period preceding application, eligibility for retroactive coverage is determined. To qualify for retroactive coverage, the applicant must meet all eligibility requirements during the retroactive period.

0372.20.30 Redeterminations

REV: June 2015

A. A redetermination of Medicaid eligibility must be made periodically to determine that the recipient continues to meet all eligibility requirements. The redetermination of eligibility is based on information provided on a new application form and documentation from the woman's treating licensed health care practitioner regarding her course of treatment. If a woman's course of treatment for breast or cervical cancer (or for a precancerous condition of the breast or

cervix) has ended, or if verification of the need for continuing treatment is not provided within the time frame specified, eligibility is discontinued.

1. A full redetermination of eligibility must be made at least every twelve (12) months, or whenever a change in circumstances occurs, or is expected to occur, that may affect eligibility.

2. Interim verification of continuing treatment, based on the reasonable expectation of the length of a woman's course of treatment, is also required. Unless otherwise specified by the woman's treating licensed health care practitioner, the expected length of time for treatment of a pre-cancerous condition is four (4) months.

0372.20.35 When Eligibility Ends

REV: February 2014

A. Eligibility for Medicaid under this coverage group ends if:

1. The woman attains age sixty-five (65);

2. She acquires creditable coverage;

3. Her course of treatment for breast or cervical cancer ends;

4. She fails to complete a scheduled redetermination;

5. She is no longer a RI resident;

6. She otherwise does not meet the eligibility requirements for the program.

B. Medicaid notification and appeal rights apply to individuals losing eligibility under this coverage group.

December 16, 2015
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