0302 Medicaid Application – Integrated Health Care Coverage Groups

REV: June 2014

A. Applicability. The Executive Office of Health and Human Services (EOHHS) has taken the opportunity pursuant to the federal Affordable Care Act (ACA) of 2010 to reorganize Medicaid/CHIP coverage groups based on the financial standard used to determine eligibility as well characteristics. All populations subject to the modified adjusted gross income (MAGI) standard have been reorganized into the Medicaid Affordable Care Coverage groups. (See the Medicaid Code of Administrative Rules (MCAR) sections 1301 and 1303). Populations exempt from the MAGI who must also meet both clinical and financial eligibility criteria have been reclassified into the Integrated Health Care Coverage (IHCC) groups. This rule applies only to persons applying for Medicaid who are in the following IHCC groups:

- Low-income adults between the ages the ages of nineteen (19) and sixty-four (64) who are blind or disabled and elders age sixty-five (65) and older.
- Persons of any age who require long-term services and supports in an institutional or home and community-based setting, including children seeking eligibility under the Katie Beckett provision.
- Low-income elders and persons with disabilities who applying for the Medicare Premium Payment Program (MPPP) in which Medicaid pays the Medicare Part A and/or Part B premiums for qualified beneficiaries.
- Medically needy individuals seeking to obtain Medicaid eligibility by applying a flexible test of income that enables the individual to "spend down" to the medically needy income limit (MNIL).

B. Contents of the Application Packet

REV: June 2014

For persons seeking Medicaid eligibility in the applicable IHCC groups under MCAR sections 0351, 0374, 0375, and 0378, the application packet consists of the following documents:

IHCC Groups
DHS-2 Application for Assistance
Medicaid Booklet
DHS-14 Office Locations
QMB-2 Information for QMB's
Transportation Information
Return Addressed Stamped Envelope

This packet provides information about the agency, the conditions under which Medicaid is provided, and an applicant's rights and responsibilities under the law. Any applicants for Medicaid health coverage in the IHCC groups must complete and submit in-person or by mail the required application documents and any additional supplemental forms that may be necessary in order for an eligibility decision to be made within the timelines set by the agency. Beginning in January 2015, applicants for Medicaid health coverage in the IHCC groups will also have the option of completing and submitting the application either:

1) on-line through the State's new web-based eligibility system;
2) in-person; or
3) by mail.

C. **Assistance in Completing the Application**
REV: June 2014

Any person applying for Medicaid health coverage may obtain the assistance of a friend, relative, attorney, guardian or legal representative, or an agency representative or other application expert working for or on behalf of the EOHHS when completing the required application forms.

D. **Application Signature or Attestation**
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All applicants for Medicaid health coverage must attest to the truthfulness of the application information they provide by hand-signing or electronically attesting to a sworn statement to that effect. Whether other members of the applicant's household or family may or must also sign the application varies as follows:

- When two spouses are living together, both spouses must sign the application form;
- A caretaker may sign and file an application form for a child with disabilities or special needs who is under the age of (19);
- A relative may file an application on behalf of a deceased individual for retroactive coverage.

E. Timeliness Standards for Decisions on Eligibility
REV: June 2014

A decision on a Medicaid application for individuals and families eligible under section 1301 of the MCAR and for persons who are blind or low-income elders in the IHCC groups is made within THIRTY (30) DAYS of the receipt of the completed application by the EOHHS, or the Department of Human Services (DHS) while operating under an agreement with the EOHHS to make eligibility determinations on its behalf. An eligibility decision for a person who has a disability and/or is seeking Medicaid-funded long-term services and supports must be made within NINETY (90) DAYS of the receipt of the completed application by the EOHHS or DHS.

(1) Good cause exemption for determination delay – IHCC groups only. An eligibility decision may exceed the timeliness standards in unusual circumstances when good cause for a delay exists. Good cause exists when:

(a) The agency representative cannot reach a decision because the applicant or the applicant's treating physician or other provider responsible for providing information material to the application delays or fails to take a required action, provided that the agency promptly reviews submitted medical and social data and requests any necessary additional medical documentation from the treating provider within two weeks from the date the completed forms (e.g., Physician's Report, Information for Determination of Disability Release of Information Authorization) are received by the agency, or within two weeks of learning of the existence of a treating provider or of the need to obtain supplementary treating provider information; or

(b) There is an administrative or other emergency beyond the agency's control. The reason for the delay must be documented in the case record. In addition, the applicant must be provided with written notification stating: the reason for delay; and the opportunity for an expedited hearing to contest the delay.

(2) Basis for making a determination. The agency representative makes the decision on eligibility on the basis of information submitted on the application. In every instance, information regarding the applicant's income is verified. Other information is verified as required. Any information on the application which is questionable must be confirmed before eligibility can be certified.

(a) If a decision cannot be made because of omissions or inconsistencies, the agency representative must contact the applicant by mail, phone, or in person for clarification, additional information, or verification. If it is necessary for the agency to obtain or confirm any information, the applicant is advised of the necessary steps the applicant or the agency must take before a determination of eligibility can be made. If other collateral sources of information must be contacted, the applicant should be informed of why the information is necessary and how it will be used by the agency. The applicant must sign a *Release of Information Authorization* and permit the State to use public records and contact collateral sources for purposes of the eligibility determination.

(b) If an applicant or beneficiary refuses to either provide the information the agency requests or sign the release(s) necessary for the agency to obtain the information on its own, the agency will deny or discontinue Medicaid health care coverage.

D. **Period of Eligibility**
REV: June 2014

Written notice is provided to each applicant stating the Medicaid agency's eligibility decision, the basis for the decision, and an applicant's right to appeal and request a hearing. In instances in which the applicant is determined to be eligible, a notice is provided indicating the length of time the applicant will remain eligible – the "*eligibility period*" -- until before a renewal of continuing eligibility is required. The period of Medicaid eligibility for IHCC group members is as follows:

(1) General eligibility period. When an individual is determined eligible for Medicaid, eligibility exists for the entire first month. Therefore, eligibility begins on the first day of the month in which the individual is determined eligible. Medicaid ends when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given or the beneficiary fails to renew eligibility as required. Medicaid benefits cease on the last day of the ten (10) day notice period when eligibility is determined to no longer exist. Individual and couple cases remain eligible for Medicaid for up to a maximum of twelve (12) months. Certifications may be for LESSER periods if a significant change occurs or is expected to occur that may affect eligibility.

(2) Special eligibility period – Medically-needy**.** In cases where the *flexible test of income* policy is applied, eligibility is established on the day the excess income is absorbed (i.e., the day the health service was provided). Eligibility is for the balance of the six (6) month period. Medically-needy eligibility continues for the full six (6) months or the balance of the six (6) month period.

(3) Medicare Premium Payment Program. Individuals eligible for benefits as a Qualified Medicare Beneficiary (QMB), a Special Low Income Medicare Beneficiary (SLMB) or a Qualified Working

Disabled Individual (QWDI) are certified for a 12-month period. A Qualifying Individual (QI-1 or QI-2) is certified to the end of the calendar year.

E . Medicaid as Payor of Last Resort
REV: June 2014

Health insurance coverage from another party is not a bar to Medicaid eligibility. However, as the payor of last resort, Medicaid payment is only made for services that are not covered by a beneficiary's other forms of health insurance. In addition, beneficiaries are required to sign over to the Medicaid agency their right to any such third party payments at the time application is made. State law makes it illegal for insurance companies to exclude Medicaid beneficiaries from benefits, reinforcing the requirement of third-party liability (TPL) and that Medicaid is the last payer. (See sections 40-8-4 and 40-6-29 of the Rhode Island General Laws, as amended).

For Further Information or to Obtain Assistance
March 2014

1. Applications for affordable coverage are available online on the following websites:
   - www.eohhs.ri.gov
   - www.dhs.ri.gov
   - www.HealthSourceRI.com

2. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

3. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

Severability
October 2013

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