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TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 50 – MEDICAID LONG-TERM SERVICES AND SUPPORTS

SUBCHAPTER 00 – LONG-TERM SERVICES

~~Part~~ PART 1 ~~–~~ Medicaid Long-Term Services and Supports Oo~~o~~verview and Eligibility Pathways

1.1 Overview

The provisions set forth herein pertain to the scope of Medicaid long-term services and supports (LTSS) and the various pathways for initial and continuing eligibility.

1.2 Legal Authority

A. This Chapter of Rules related to Medicaid LTSS is promulgated pursuant to Federal authorities as follows:

1. Federal Law: Title XIX of the U.S. Social Security Act 42 U.S.C. §§ 1396a, 1115, 1902, 1903, 1905, 1915; 1396k; and 1413(b)(1)(A) of the Affordable Care Act.

2. Federal Regulations: 42 C.F.R. Parts 431,435, 440, and 441.

3. The Medicaid State Plan and the Title XIX, Section 1115 (a) Demonstration Waiver (11-W-00242/1), effective through December 31, 2018.

B. Additionally, legal authority related to LTSS is derived from R.I. Gen. Laws Chapter 40-8 and R.I. Gen. Laws §§ 40-8.6 to 40-8.13.

1.3 Definitions

A. For the purposes of LTSS Medicaid, the following definitions apply:

1. “Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals" or "BHDDH” means the S~~s~~tate agency established under the provisions of R.I. Gen. Laws Chapter 40.1-1 whose duty it is to serve as the State’s mental health authority and establish and promulgate the overall plans, policies, objectives, and priorities for State programs for adults with intellectual and developmental disabilities as well mental illness and substance abuse education, prevention and treatment.

2. “Department of Human Services" or "DHS” means the State agency established under the provisions of R.I. Gen. Laws Chapter 40-1 that is empowered to administer certain human services. The DHS has been delegated the authority through an interagency service agreement with the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, to determine Medicaid eligibility in accordance with applicable State and Federal laws, Rules and Regulations.

3. “Developmental disability” means, for the purposes of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, a condition that affects a person, eighteen (18) years or older, who is either an intellectually developmentally disabled adult or a person with a severe, chronic disability that:

    a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;

    b. Manifests before the person attains age twenty-two (22);

    c. Is likely to continue indefinitely;

    d. Results in substantial functional limitations in three (3) or more of the following areas of major life activity:

        (1) Personal care

        (2) Communication

        (3) Mobility

        (4) Learning

        (5) Self-direction

        (6) Capacity for independent living

        (7) Economic self-sufficiency; and

        (8) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services which are life-long or of extended duration and are individually planned and coordinated.

4. "Eligibility date" means the first (1st) day of the month in which a person is eligible for Medicaid LTSS. It is based on the month the application or, for existing beneficiaries, the request for LTSS is made and is otherwise unrelated to the date a person entered an institution or began receiving

LTSS, regardless of payer. The eligibility date does not include periods of retroactive eligibility.

5. “Executive Office of Health and Human Services" or "EOHHS” means the State agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 within the executive branch of State government which serves as the principal agency for managing the Departments of Children, Youth, and Families (DCYF); Health (RIDOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).

6. “Financial eligibility” means the set of factors used to determine whether a person is entitled to receive services based upon income and/or resource requirements, as well as limitations related to the transfer of assets, which includes both liquid resources and real property, prior to the application for Medicaid LTSS.

7. “Functional disability” means any long-term limitation resulting from an illness, health condition, or impairment that affects a person’s ability to perform certain activities of daily living without substantial assistance or supervision.

8. “Home and Community-Based Services" or "HCBS” means any Medicaid LTSS State Plan or Section 1115 waiver-authorized services available to beneficiaries at home or in a community-based setting.

9. “Institution” or "Health institution" means a State-licensed health facility that provides health and/or social services and supports on an in-patient basis. For the purposes of this Rule, the term means long-term care hospitals and treatment facilities (LTH), intermediate care facilities for persons with intellectual disabilities (ICF/ID), and nursing facilities (NF).

10. “Integrated Health Care Coverage Groups” or "IHCC" means any Medicaid coverage group consisting of adults who are eligible based on receipt of Supplemental Security Income (SSI), SSI protected status, the SSI income methodology and a related characteristic (age or disability), or as a result of participation in another Federal or State program, such as the Breast and Cervical Cancer Program. This group includes beneficiaries eligible for community Medicaid (non-long-term care), Medicaid-funded LTSS and the Medicare Premium Payment Program (MPPP).

11. “Integrated Health and Human Services Eligibility System" or "IES” means the State's eligibility system that enables applicants, through a single application, to be considered for multiple health and human service programs simultaneously.

12. “Intermediate Care Facility for Persons with Intellectual/Developmental Disabilities" or "ICF/ID” means a State-licensed health care facility that provides long-term services and supports to persons with intellectual/developmental disabilities.

13. “Katie Beckett eligibility” means an eligibility category that allows certain children under age nineteen (19) who have long-term disabilities or complex medical needs who require an institutional level of care to obtain the Medicaid long-term services they need at home. With Katie Beckett eligibility, only the child’s income and resources are considered when determining eligibility.

14. “Long-term services and supports" or "LTSS" means a spectrum of services covered by the Medicaid program for persons with clinical and functional impairments and/or chronic illness or diseases that require the level of care typically provided in a health care institution. Medicaid LTSS includes skilled or custodial nursing facility care, therapeutic day services, and personal care as well as various home and community-based services. Medicaid beneficiaries eligible for LTSS are also provided with primary care essential benefits. The scope of these services and supports and the choice of settings is determined by a comprehensive assessment of each person's unique care needs.

15. “LTSS living arrangement” means the institutional or home or community-based setting where a Medicaid LTSS beneficiary resides while receiving Medicaid LTSS.

16. “LTSS specialist” means a State agency representative responsible for conducting assessments, determining eligibility for LTSS, authorizing services, and/or providing assistance to people in navigating the Medicaid LTSS system.

17. “Medicaid Affordable Care Coverage Groups” or "MACC" means a classification of persons eligible to receive Medicaid who are subject to the Modified Adjusted Gross Income or "MAGI" standard for determining income eligibility as outlined in the Medicaid Code of Administrative Rules, ~~"~~ Medicaid MAGI Financial Eligibility Determinations and Verification ~~Health Coverage for Children, Families, and Adults"~~ (See Part 30-00-5 of this Title).

18. “MAGI standard” means the method for evaluating Medicaid income eligibility using the modified adjusted gross income (MAGI) standard established under the ACA. Persons who are or would be income-eligible for the ACA expansion for adults may obtain Medicaid LTSS if they meet the applicable clinical/functional eligibility criteria, are under age sixty-five (65), and are not eligible for or enrolled in Medicare.

19. "Medicaid single state agency" means the State agency authorized under State law, Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) and the Medicaid State Plan as the entity legally responsible for the program/fiscal management and administration of the Medicaid program. The EOHHS is the designated single state agency in Rhode Island.

20. “Needs-based criteria” means the basis for determining clinical/functional eligibility for Medicaid LTSS. The LTSS needs-based criteria encompass medical, social, functional, and behavioral factors, and the availability of family support and financial resources.

21. “Preadmission Screening and Resident Review" or "PASRR” means the process required by Federal law that evaluates and ensures individuals who have a serious mental illness (SMI) and/or intellectual disability are not inappropriately placed in nursing facilities for long-term care. PASRR requires that those applicants for a Medicaid-certified nursing facility are evaluated for appropriateness.

22. “Primary care essential benefits” means non-LTSS Medicaid health coverage, and includes an array of acute, subacute, and specialty essential benefits, as identified under the Medicaid State Plan, provided by licensed health professionals. These essential benefits include, but are not limited to: health promotion, disease prevention, health maintenance, counseling, patient education, various specialty services and diagnosis and treatment of acute and chronic medical and behavioral health illnesses and conditions in a variety of health care settings such as office visits, inpatient, home care, and day care.

1.4 Types of LTSS

A. Under the terms of Title XIX of the U.S. Social Security Act of 1964, Medicaid LTSS in an institutional-setting is a State Plan service available to all otherwise eligible Medicaid beneficiaries and new applicants, providing they meet certain eligibility factors.

B. “Institution” is the term used in Title XIX to refer to a hospital (H), an intermediate care facility for persons with intellectual/developmental disabilities (ICF/ID), and a nursing facility (NF). These institutions are licensed in Rhode Island by the Department of Health (RIDOH) as health care facilities under Chapter 23-17 of the R.I. Gen. Laws. Although the term "institution" is not accurate in a licensure sense, under federal regulations at 42 C.F.R. § 440.40, the eligibility criteria for Medicaid LTSS remain tied to these institutional settings and vary in accordance with types of services each typically provides and the needs of the population(s) they serve. As these services are now also available to beneficiaries in a home and community-based setting, the Medicaid LTSS Rules apply across settings, as follows:

1. Medicaid LTSS in Health Care Institutions – Persons who meet the applicable eligibility requirements may access LTSS in the following State-licensed health care institutions/facilities

    a. Nursing Facilities (NF). A person is eligible to access Medicaid LTSS in a NF when it is determined, based on a comprehensive assessment, that he or she has the highest need for a NF level of care.

    b. Intermediate Care Facility for persons with Intellectual/Developmental Disabilities (ICF/ID). To qualify, a person must meet the applicable statutory standards set forth in R.I. Gen. Laws § 40.1-22-6 pertaining to developmental disabilities and:

        (1) have the level of need for LTSS typically provided in an ICF-ID; or

        (2) would require an ICF/ID level of care if were not for LTSS provided in a home or community based setting. As the State's Section 1115 waiver provides the authority for the home and community-based LTSS provided to members of this population with developmental disabilities, the BHDDH is required to provide services in the least restrictive setting appropriate to a person's level of care needs.

    c. Long-term Hospital (LTH) – A person must meet the needs-based criteria for long-term services in a hospital setting established by BHDDH and/or the EOHHS. Medicaid LTSS may also be available to children in State custody or with special health care needs receiving services in residential treatment facilities and hospitals if they meet the applicable level of care requirements.

2. Medicaid Home and Community-based (HCBS) LTSS – The State’s Section 1115 demonstration waiver authorizes Medicaid LTSS when provided in a home and offers an array of community-based settings as an alternative to care in one (1) of the three (3) principal covered health care institutions (NF, ICF/ID, or LTH). Access to these services enables beneficiaries to optimize their health and retain their independence while delaying or diverting the need for care in a more restrictive health care institutional setting.

    a. Scope of HCBS Coverage. Medicaid HCBS includes both core and specialized services and supports authorized under the State Plan or Section 1115 demonstration that address each individual beneficiary's unique long-term functional and clinical needs. The array of HCBS may vary depending on the beneficiary’s needs and the institutional level of care required.

b. Limitations. Room and board are NOT covered for HCBS by Medicaid.

1.5 Applicability

The provisions set forth herein apply to any person seeking Medicaid LTSS coverage, including those who are uninsured, receiving non-LTSS Medicaid under Part 40-00-3 of ~~Chapter 40 of~~ this Title or "Medicaid Integrated Health Care Coverage, SSI Financial Eligibility Determinations~~MCAR 1305, "Eligibility Requirements~~", or have third (3rd) party forms of coverage through Medicare or a commercial insurer.

1.6 Scope of LTSS Coverage

A. Upon being determined eligible for Medicaid LTSS, a beneficiary is entitled to Medicaid State Plan and Section 1115 waiver services across the care continuum. Subchapters 05 and 10 of this Chapter identify the LTSS covered services and the various Medicaid LTSS programs that serve beneficiaries with specific types of health needs, including the following:

1. Primary care essential benefits. All LTSS Medicaid beneficiaries are entitled to receive the primary care essential health benefits available to beneficiaries in the MACC and IHCC groups, covered under the Medicaid State Plan and Section 1115 demonstration waiver, including primary and preventive care as well as acute and subacute services. If a beneficiary has third (3rd) party insurance, such as Medicare or commercial insurance that does not provide the full scope of Medicaid benefits, Medicaid provides wrap-around coverage for any Medicaid services that are unavailable.

2. Institutional and home and community-based care. Medicaid LTSS beneficiaries are eligible for the full scope of LTSS covered by the Medicaid State Plan and Section 1115 waiver. As the State uses needs-based criteria to determine the scope of services a beneficiary is authorized to receive, Medicaid LTSS coverage varies along with a beneficiary's functional capacity and acuity needs, social environment, access to family and other third (3rd) party supports, and personal choices. The range of Medicaid LTSS extends from 24/7 comprehensive care in a health institution to a limited package of services in a community-based setting, to one (1), a few, or a bundle of home and community core and ancillary services in the home.

B. Medicaid beneficiaries who are receiving primary care essential benefits through a managed care plan or fee-for-service through a MACC group MAGI pathway pursuant to Part 30-00-1 of this Title (ACA Expansion Adults) or a IHCC group SSI (Supplemental Security Income or SSI eligible and SSI-protected status and Elders and Adults with Disabilities or EAD) pathway in accordance with Part 40-

00-1 of this Title may be eligible for Medicaid LTSS preventive (see § 40-05-1.8 of this Title) or full benefits if they meet certain clinical/functional and financial eligibility criteria. The State uses information known about the beneficiary when determining eligibility for LTSS for current Medicaid beneficiaries to the full extent feasible. The additional information required, as out-lined below, may be provided by completing the applicable sections of the DHS-2 form, or designated supplemental form, or by updating an on-line account as appropriate:

Basis of Eligibility	**Supplemental Information Required from Existing Beneficiaries Seeking LTSS**			
	Preventive **LTSS Clinical/function** **(See Part 40-05-1 of this Title)**	**Functional/clinical** **Level of Need (See Part 5 of this Subchapter)**	**Financial Eligibility – Allocation of resources and transfer of assets – Part 40-00-3 of this Title and Part 6 of this Subchapter)**	**Post-eligibility Treatment of Income (See Part 8 of this Subchapter)**
1.SSI	Documentation from health provider	Documentation from health provider	Limited to current information on spouse and dependents as related to spousal impoverishment and transfer of assets	Applies – information related to allowances including income and expenses of spouse and dependents
2. EAD	Documentation from health provider	Documentation from health provider	Limited to sixty (60) months pre-application of information on spouse and dependents as related to spousal impoverishment and transfer of assets	Applies – information related to allowances income and expenses of spouse and dependents
3. ACA Expansion Adults	Not applicable	Documentation from health provider	Limited sixty (60) months of pre-application information on resources of self, spouse and dependents as related to transfer of assets only	Not applicable

1.7 Qualifying for Medicaid LTSS

A. Under Title XIX, the federal Medicaid law, an applicant for LTSS must be either a current beneficiary or possess an income, clinical/functional, or age-related characteristic related to a MAGI eligible or SSI population AND have an established need to qualify to apply. With the enactment of the Federal Affordable Care Act of 2010, Federal law requires that Medicare, commercial health insurers, and group health plans provide as part of the primary care essential benefit package up to thirty (30) days of subacute and rehabilitative care for persons who have had an acute care incident requiring services in a health institution. Medicaid is also required to provide this benefit. Both existing beneficiaries and new applicants must have established a continuing need for LTSS -- that is, for an institutional level of care -- to qualify for Medicaid LTSS once the thirty (30) days of essential benefit coverage is exhausted. This need in previous Rhode Island Medicaid Rules was referred to as “considered institutionalized” for the purposes of determining Medicaid LTSS eligibility as indicated below:

1. Existing beneficiaries – Under the Medicaid State Plan, all Medicaid beneficiaries are eligible for up to thirty (30) days of LTSS coverage in addition to the required thirty (30) day essential benefit period of acute and subacute care in a health care institution as part of their non-LTSS primary essential benefit coverage. A separate determination of eligibility or change in service delivery is not required for this period of coverage. Therefore, an existing beneficiary may qualify to apply for Medicaid LTSS without a change in eligibility or service delivery options if they have received the required period of continuous coverage is provided in this manner or, if seeking LTSS in the home and community-based setting, they require or are receiving at least one (1) Medicaid covered LTSS benefit to address a functional need that otherwise would require care in an institutional setting. The Medicaid MCOs and DHS eligibility specialists are available to provide assistance to existing beneficiaries during this period.

2. New applicants – New Applicants are considered to have such a need if they have met one (1) of the following:

    a. Received the level of services typically provided in a NF, ICF-ID, or LTH setting for at least thirty (30) consecutive days and are expected to have a continued need for such services or have:

        (1) Obtained acute care services in a hospital or similar health facility for at least thirty (30) consecutive days and are seeking LTSS;

(2) Received Medicaid preventive level services while residing at home or in a community-based care setting for at least thirty (30) consecutive days;

(3) Been determined to have needs that require the level of services typically provided in a health care institution for at least thirty (30) consecutive days or would require such services were those in the home and community-based setting not provided.

b. Received or required at least one (1) Medicaid covered LTSS benefit at home or in a community-based setting to address a functional/clinical need that would otherwise necessitate the type of LTSS typically provided in a health institution.

1.8 Eligibility Determination Process

A. There is a multiphase process for determining eligibility and authorization for Medicaid LTSS that includes the following steps:

1. Information, Referral, Options Counseling – Prior to initiating the application process and/or at any step during the eligibility determination sequence, applicants and/or their family members or authorized representatives may seek information, referral and/or options counseling to assist them in navigating the LTSS system. Part 4 of this Subchapter sets forth role of this service.

2. Person-centered Planning – Upon making application for LTSS, the person-centered planning process must begin for anyone seeking HCBS. The process is available, at the applicant's option, for LTSS in a health care institution as well. Person-centered planning is an individualized approach to planning that places the applicant at the center of decision-making thereby enabling him/her to direct his/her own services and supports in accordance with his/her own desires, goals and preferences, with impartial assistance and supported decision-making when helpful. Accordingly, the person-centered planning is an on-going process that continues through the eligibility determination process through to the authorization of services and thereafter. In accordance with 45 C.F.R. § 441.301(c)(1), the State must ensure that throughout this process, the applicant has sufficient and necessary information in a form he/she can understand to make informed choices and direct the planning process to the maximum extent possible. See Part 4 of this Subchapter for specific provisions.

3. Eligibility Determination Factors – To gain access to LTSS, the information provided by applicants is evaluated across the eligibility factors identified below, though not necessarily in a specific order:

a. General eligibility factors. All persons seeking initial or continuing Medicaid LTSS must meet the general requirements for the program related to residency, citizenship and immigration status, and Social Security Numbers and the like. The application form must be completed and signed along with the authorizations necessary to conduct electronic data matches to verify income and resources; and to request personal health information to assess and review clinical/functional level of need. General eligibility factors for MACC MAGI-based LTSS eligibility are located in § 30-00-1.5(C) of this Title and for SSI-based LTSS eligibility in Part 5 of this Subchapter. Existing beneficiaries seeking LTSS must only update general eligibility information if there have been changes since the point of their last renewal.

b. Clinical/functional eligibility factors. An assessment of clinical and functional needs serves as the basis for a level of care determination and is conducted for all persons seeking Medicaid LTSS, without regard to eligibility pathway. This assessment is based on needs-based criteria that evaluate clinical, functional, social and behavioral needs as well as environmental factors. A Medicaid Assessment and Review Team (MART) determination of disability status is not required unless the applicant is seeking LTSS coverage while working through the Sherlock Plan or unless the applicant has been deemed to have a disability by the Social Security Administration. In response to the novel Coronavirus Disease (COVID-19), until the end of the Federal declaration of the COVID-19 public health emergency, EOHHS will temporarily conduct level of care determinations/redeterminations for all LTSS eligibility pathways via phone and physician records. The responsibilities for assessing need vary for each institutional level of care as follows:

(1) Nursing Facility. The State established clinical and functional disability criteria under the Section 1115 waiver which assess the scope of a beneficiary's need for a NF level of care. The EOHHS is responsible for assessing the level of need of persons seeking Medicaid coverage of LTSS typically provided in a NF and long-term hospital care, including home and community-based alternatives. As indicated in Part 5 of this Subchapter, the scope of a person's clinical/functional need for a NF level of care (high or highest) affects the type of LTSS available to the person and thus the choice of setting (institutional and/or HCBS).

(2) Intermediate care facilities for persons with intellectual disabilities. The BHDDH uses needs-based criteria to evaluate clinical/functional eligibility for the ICF/ID level of

care that incorporate the requirements set forth in State law (R.I. Gen. Laws § 40.1-22-6), the scope of services and supports required, and the impact of familial, social, and environmental factors that affect the choice of setting.

(3) Long-term Hospital Care. Each agency serving beneficiaries who may require Medicaid LTSS in a hospital setting is authorized under the State's 1115 waiver to tailor the clinical/functional criteria to meet their population's general and unique needs within the parameters of applicable Federal Regulations and laws. This applies to persons seeking services through the EOHHS Habilitation Program that were authorized prior to establishment of the Section 1115 demonstration in 2009 under the State's § 1915(c) Habilitation Waiver and the various programs administered by the BHDDH. EOHHS determines clinical/functional eligibility for applicants seeking an LTH level of care through the Medicaid Habilitation program and certain persons referred by the BHDDH for admission to the State's Eleanor Slater Hospital.

(4) Children with Special Health Care Needs. Children with disabilities and/or serious chronic and disabling conditions may require a NF, ICF/ID or LTH level of care at home or in an institutional-setting. The process for assessing level of need for children who are eligible based on the MAGI, SSI or custody of the State's Department of Children, Youth and Families (DCYF) is conducted by multiple entities under the auspices of the early, periodic, screening, detection and treatment (EPSDT) in Part 30-00-1 of this Title. The designated unit of EOHHS determines clinical/functional eligibility for children who do not qualify for coverage through one (1) of these pathways and are seeking coverage of LTSS in a home setting in accordance with the provisions located in Subchapter 10 Part 3 of this Chapter. Continuing eligibility for current beneficiaries is based on the method used to determine initial eligibility and, if no basis for coverage is found, across the remaining pathways.

c. Financial Eligibility Factors. LTSS eligibility specialists in the Department of Human Services (DHS) are responsible for determining financial eligibility through the IES and related systems. The financial requirements pertain to an array of factors including the calculation of countable income and resources using the MAGI or SSI method and the allocation of resources and transfer of asset requirements that are unique to the determination of LTSS eligibility. Both of the following apply to new and existing

beneficiaries seeking LTSS without regard to basis of eligibility and are explained in greater detail in Part 6 of this Subchapter.

(1) Allocation of resources with spouses/dependents. The evaluation and allocation of resources at the point the need for LTSS is established and/or at the time of application is required for LTSS applicants who have spouses. This process, referred to as the Community (Non-LTSS) Spouse Resource Allowance (SRA), allocates the joint resources of couples in accordance with Federal standards to ensure a sufficient amount is protected for the non-LTSS spouse's needs – that is, unavailable to pay for the costs of care for the LTSS applicant/beneficiary. The allocation of resources at this state of the eligibility process is distinct from that which occurs when determining the amount of income a beneficiary must pay toward the cost of care in the "post-eligibility" treatment of income. LTSS MAGI beneficiaries are subject to allocation of resource requirements but are exempt from the post-eligibility treatment process.

(2) Transfer of assets. The determination of financial eligibility for Medicaid LTSS requires that the State review whether an applicant made a "disqualifying" transfer of assets – liquid resources and real property – in the sixty (60) month period before the need for LTSS was established. A transfer is deemed to be disqualifying if the asset was conveyed for less than fair market value. Under Federal law, such a transfer is presumed to have been made to reduce assets for the expressed purpose of gaining Medicaid LTSS eligibility. The State is required to impose a penalty period, during which Medicaid coverage for LTSS is unavailable, that is equal to the amount of the disqualifying transfer divided by the average cost of care at the private pay rate.

B. Once eligibility has been determined, payment for Medicaid LTSS becomes available only after the following inter-related steps are completed:

1. Service Plan ~~–~~ Development of a service plan ensures that a beneficiary is or will be able to attain the full scope of services required to meet his/~~ or~~ her needs in the choice of LTSS living arrangement. Towards this end, LTSS specialists from across the EOHHS agencies and their community partners and contractual agents consider the results of the clinical/functional needs-based assessment, more intensive evaluations, as appropriate, and/or the consensus decisions made in the person-centered planning process for HCBS or the results of the PASRR for nursing facility care to help ensure that every beneficiary receives the right services, at the right time, and in the most appropriate setting.

2. Post-Eligibility Treatment of Income (PETI) – Under the State's Section 1115 waiver, all non-MAGI eligible LTSS beneficiaries are subject to the PETI process. PETI is the basis for calculating a beneficiary's liability to pay toward the cost of care. During this process, income is evaluated a second (2nd) time, Federal spousal impoverishment requirements are applied, if appropriate, and additional deductions from income are taken for personal needs, non-covered health care costs like insurance premiums, and other allowable expenses. PETI varies somewhat depending on the type of Medicaid LTSS – in a health institution or HCBS – selected by a beneficiary and the requirements of his/her service plan. Accordingly, the development of the service plan and the beneficiary's health care priorities and preferences established in the person-centered planning process are important factors that must be considered when calculating beneficiary liability. The PETI process is set forth in detail in Part 8 of this Subchapter.

3. Authorization of Payment for LTSS – Authorization of Medicaid LTSS is required before a payment is made for coverage provided to a beneficiary. This process entails a complex set of transactions in which information about the scope of services approved and/or utilized and the beneficiary's liability are transmitted from the IES to the State's Medicaid claims system (Medicaid Management Information System or "MMIS"). Once these transactions are completed, payment is authorized to an LTSS provider dating back to the eligibility date – the first (1st) day of the month in which the application was filed – and prospectively unless retroactive eligibility has been approved.

1.9 Eligibility Pathways

A. The eligibility pathways available to persons seeking Medicaid LTSS have different requirements all of which are automatically taken into account when application information is processed. As indicated below, the process for determining eligibility and the sequence may vary for members of a particular population depending on the pathways available.

1. SSI and SSI-related Groups – SSI recipients and members of certain SSI-related groups are automatically eligibility for Medicaid based on a determination by SSA as indicated in Part 40-00-3 of this Title. Federal Regulations at 42 C.F.R. § 435.603(j) specifically exclude Medicaid determinations of eligibility for members of this group, including for LTSS, using the MAGI standard except in instances in which an SSI recipient no longer meets disability criteria and loses cash assistance on this basis. Special provisions also apply to Medicaid LTSS beneficiaries who are receiving SSI and are expected to need LTSS coverage for ninety (90) days or less. Accordingly, access to LTSS proceeds as follows:

a. Eligibility Criteria. Medicaid beneficiaries who are SSI-eligible and need LTSS are subject to the clinical/functional eligibility factors required for an institutional level of care set forth in Subchapter 05 Part 1 of this Chapter as well as the financial eligibility requirements related to the transfer of assets. The resource limit is set at two thousand dollars ($2,000.00).

b. Special Conditions. Re-evaluation of income and resources is not required unless current eligibility is based on different Medicaid group size (couple v. individual) or there is a change in income or resources resulting from need for or use of LTSS. In addition:

(1) SSI recipients who have § 1619(b) status, as indicated in § 40-05-1.5.4 of this Title, remain eligible for two (2) months of continuing SSI cash assistance if admitted to an LTH, such as Eleanor Slater Hospital or an equivalent HCBS setting; and

(2) SSI recipients who obtain Medicaid LTSS for a period not expected to exceed ninety (90) days may continue to receive SSI cash assistance during this time to maintain a community residence. Such income is excluded in the financial eligibility determination sequence, including the post-eligibility treatment of income.

c. Determination Process. SSI recipients are not subject to a MAGI determination and a re-evaluation of income/resource eligibility using the SSI method is not required when applying for LTSS. Although a review of functional/clinical eligibility is conducted, a full assessment of level of care needs may be waived for certain populations based on their type of disability as indicated in Part 5 of this Subchapter. All other steps in the eligibility determination process apply to the extent that the special Rules applicable to the treatment of SSI income allow, as indicated in Part 40-00-3 of this Title.

d. Retroactive Coverage. Retroactive coverage is available for any allowable non-Medicaid covered LTSS expenses in the ninety (90) day period prior to the eligibility date in circumstances in which the applicant for LTSS was not enrolled in Medicaid at that time.

2. Adults 19 to 64 – All persons seeking initial or continuing eligibility for Medicaid LTSS in this age group are evaluated across several pathways unless they are currently eligible for Medicaid.

a. Eligibility Criteria. Applicants are subject to the general and functional/clinical eligibility requirements. Not all financial eligibility

factors such as resource limits apply, as indicated. The financial eligibility requirements vary across pathways; if a beneficiary is determined ineligible in the current category (existing beneficiaries) or a pathway of choice (new applicants), the IES automatically evaluates whether eligibility through another pathway exists up to and including the medically needy pathway. The process generally proceeds as follows:

(1) MACC Group for MAGI-eligible Adults: Income limit – one hundred thirty-three percent (133%) of the FPL; No resource limit.

(2) IHCC non-SSI eligible Adults with Disabilities in Community Medicaid: Income limit – one hundred percent (100%) of the FPL; Resource Limit – four thousand dollars ($4,000.00). Applies to new applicants and existing beneficiaries.

(3) Special Income/HCBS: Income limit – three hundred percent (300%) of the SSI standard; Resource Limit – four thousand dollars ($4,000.00). New applicants only.

(4) Medically Needy: Income limit – Cost of Care; Resource Limit – four thousand dollars ($4,000.00). New applicants only

b. Special Conditions. Several eligibility pathways have special conditions that target or exclude certain populations:

(1) MACC Group for MAGI-eligible Adults: Pathway is closed to persons who are sixty-five (65) and older or who are eligible for or enrolled in Medicare. In addition to the exemption from a resource limit, PETI rules do not apply and, as a result, beneficiaries in this group do not have to pay a portion of income toward the cost of care. Spousal impoverishment protections, guaranteed through the SSI method, are also unavailable through this pathway.

(2) IHCC non-SSI adults with disabilities in Community Medicaid: Current beneficiaries may request to be assessed for an LTSS level of care and provide only the information related to financial eligibility factors to evaluate the transfer of assets, the allocation of resources between spouses/dependents, and beneficiary liability in accordance with Part 8 of this Subchapter. Existing beneficiaries seeking Medicaid LTSS under the Sherlock Plan must apply pursuant to the requirements set forth in Part 40-15-1 of this Title.

(3) Special Income: Pathway for new applicants with income above the Community Medicaid limit (up to three hundred percent (300%) of the SSI benefit rate) and adults with disabilities in the IHCC medically needy group who are seeking care in a health institution such as a hospital or nursing facility.

(4) HCBS: Reserved for persons seeking Medicaid LTSS in the HCBS setting who would, absent these services, have the "high" or "highest" need for an institutional level of care. Generally, these are new applicants for Medicaid.

(5) Medically Needy: Countable income must be below the average cost of care in the applicable institutional setting, as set forth in Part 40-05-2 of this Title. Special income deductions also apply.

c. Determination Process. The principal distinction in the determination process aside from the difference in eligibility criteria is the method for evaluating income – MAGI v. SSI – as indicated below:

(1) New Applicants for Medicaid -- When applying for Medicaid LTSS, all new applicants who are under age sixty-five (65) and are neither enrolled in or eligible for Medicare are evaluated first to determine whether eligibility using the MAGI method for the MACC group for adults exists. Transfer of asset requirements are applied and an applicant must provide any information about liquid resources and real property necessary to complete that step in the eligibility process. If a new applicant under age sixty-five (65) is found ineligible for the MAGI-based MACC group coverage, or is requesting retroactive coverage, the SSI method is used to determine financial eligibility and all steps in the LTSS determination process, including PETI apply.

(2) Current Medicaid Beneficiaries – Current Medicaid beneficiaries who are seeking LTSS remain within the eligibility category that serves as the basis for their existing eligibility and are only referred as appropriate if LTSS eligibility in this category would be denied due to the supplemental information provided when seeking LTSS. Adults with disabilities who are receiving non-LTSS Community Medicaid under Chapter 40 of this Title are referred for a determination of clinical/functional eligibility, in the same manner as those who are SSI-eligible, while the required financial eligibility factors unique to LTSS are

reviewed. All beneficiaries can initiate the LTSS eligibility determination by contacting a DHS LTSS eligibility specialist and completing the applicable sections of the integrated health and human services application form, or an alternative form designated for this purpose, or updating their accounts in the IES Consumer Portal.

d. Retroactive Coverage. Retroactive coverage for up to ninety (90) days is available for LTSS applicants in this population who are determined eligible using the SSI method. Under the terms of the State's Section 1115 demonstration waiver, all MAGI-eligible MACC groups, including the ACA expansion adults, do not have access to retroactive coverage unless eligible as a pregnant woman under the terms and conditions of the State's Section 1115 waiver.

3. Elders 65 and older – The eligibility pathways for persons sixty-five (65) years of age and older vary somewhat when compared to those available for persons between nineteen (19) and sixty-four (64) as specified above. The chief distinction is that members of this population are not evaluated for MAGI-based eligibility even if they are the parents/caretakers of a Medicaid eligible child. Differences in criteria by pathway are as follows:

a. Eligibility Criteria. All persons seeking Medicaid LTSS are evaluated using the SSI method through to the authorization of services; MAGI-based eligibility is not permitted under applicable Federal law. Although the income requirements vary, the resource limit is four thousand dollars ($4,000.00) for an individual applicant across pathways:

(1) IHCC non-SSI eligible elders in Community Medicaid: Income limit – one hundred percent (100%) of the FPL; Resource Limit – four thousand dollars ($4,000.00).

(2) Special Income/HCBS: Income limit – three hundred percent (300%) of the SSI standard; Resource Limit – four thousand dollars ($4,000.00).

(3) Medically Needy: Income limit – Cost of Care; Resource Limit – four thousand dollars ($4,000.00).

b. Special Conditions. The special conditions for adults with disabilities whose eligibility is determined using the SSI method also apply to elders.

c. Determination Process. The principal distinction in the determination process for members of this population is also a function of whether a person is a new applicant or current Medicaid beneficiary.

(1) New Applicants for Medicaid – When applying for Medicaid LTSS, all new applicants who are sixty-five (65) year of age and older are subject to a full financial eligibility review using the SSI method as well a determination of clinical/functional eligibility and all the steps in the LTSS determination process, including PETI apply.

(2) Current Medicaid Beneficiaries – Current Medicaid beneficiaries who are sixty-five (65) and older and eligible and receiving non-LTSS MACC Medicaid as a parent/caretaker under Chapter 30 of this Title are referred for both a full financial eligibility review using the SSI method, which requires that they provide additional information related to their own and joint spousal resources, and functional/clinical eligibility review. Current beneficiaries eligible for non-LTSS Community Medicaid under Chapter 40 of this Title are referred for a determination of clinical/functional eligibility, in the same manner as those who are SSI-eligible, while the required financial eligibility factors unique to LTSS are reviewed. All beneficiaries can initiate the LTSS eligibility determination by contacting a DHS LTSS eligibility specialist and completing the applicable sections of the integrated health and human services application form, or an alternative form designated for this purpose, or updating their accounts in the IES Consumer Portal.

d. Retroactive Coverage. Retroactive coverage is available for a period of up to ninety (90) day for LTSS applicants evaluated on the basis of the SSI method. Accordingly, all elders are eligible for retroactive coverage.

4. Children up to Age 19 – Children requiring LTSS are generally evaluated for MACC group eligibility and provided the services and supports they need under the authorities included in the Medicaid State Plan without requiring a separate determination of eligibility. As indicated in Subchapter 10 Part 3 of this Chapter, there is also a separate eligibility pathway known as Katie Beckett (KB), which was established by Congress for children with serious illnesses and/or disabilities who are receiving care at home and, as a result, would otherwise be ineligible for Medicaid. These children would most likely be eligible if they were receiving care in an institution. The KB pathway, which is named after the young woman who inspired its creation by Congress, applies the SSI institutional Rules to provide Medicaid coverage available to these otherwise ineligible children by deeming their parents' income as unavailable to them. Accordingly, children eligible through the KB pathway receive the full scope of Medicaid State Plan and Section 1115 waiver services, including Early, Periodic,

Screening, Detection and Treatment (EPSDT), provided to children with severe chronic diseases and/or disabling impairments who qualify in the MACC group pathway based on MAGI pursuant to Subchapter 10 Part 3 of this Chapter. The eligibility pathways differ as follows:

a. Eligibility Criteria. All children seeking initial or continuing eligibility for Medicaid LTSS coverage must meet the general requirements for eligibility. Financial and clinical requirements vary depending on pathway. Eligibility standards by pathway are set at:

(1) MACC group for children: Family income limit – two hundred sixty-one percent (261%) FPL; no resource limit.

(2) Katie Beckett: Child income limit – Special income limit for LTSS – Federal benefit rate; resource limit – four thousand dollars ($4,000.00); no income or resource deeming.

b. Special Conditions. The special conditions apply only to the KB eligibility pathway. To be eligible, the child must have a disabling impairment and needs requiring the level of care typically provided in a health institution (NF, ICF-ID, LTH) and live at home. A cost-effectiveness test applies; that is, the cost of care at home must be at or below cost of care provided in a health care institution. The child must be otherwise ineligible for Medicaid based on family income,

c. Determination Process. The eligibility system considers all children seeking Medicaid eligibility in the MACC group for children first, in accordance with the income limits set in Part 30-00-1 of this Title and the MAGI eligibility process in Part 30-00-5 of this Title.

d. Retroactive Coverage. Retroactive coverage is available for KB eligible beneficiaries, but is unavailable for MACC group eligible beneficiaries, including children with special needs.

1.10 Expedited Eligibility

A. Expedited eligibility is a special process authorized under the State's Section 1115 demonstration for adults age nineteen (19) and over seeking LTSS in a home and community-based setting. The purpose of this special process is to provide a limited package of HCBS for no more than ninety (90) days to applicants who meet the need for LTSS in a home or community-based setting as specified in § 1.7(A)(2)(b) of this Part and prefer to remain in or transition to a home or community-based setting for a health institution while a full determination of eligibility is being made.

1. Eligibility criteria – To be considered for expedited eligibility, new applicants must submit a full and completed application for Medicaid LTSS and self-attest to meeting the Medicaid LTSS general and financial eligibility requirements for their appropriate coverage group – that is, elder, adult with disability, MACC group adult and so forth. Existing beneficiaries must notify an LTSS eligibility specialist and provide any supplemental information required to initiate an expedited eligibility review. The need for LTSS must be established in accordance with applicable functional/clinical criteria established by EOHHS by a licensed treating physician or appropriately qualified health practitioner or provider.

2. Applicable circumstances – Expedited eligibility is the default eligibility for new applicants and existing non-LTSS Medicaid beneficiaries who meet the requirements set forth in this Part in the following circumstances:

    a. Discharge from a hospital. Discharge must be to a home or community-based setting from a hospital or ancillary health institution after an acute care admission.

    b. Discharge from a from a short-term health institution stay Discharge or transition to a home and community-based setting from a nursing facility or subacute care facility for a short-term stay or skilled rehabilitation if the services provided are not covered as a Medicaid LTSS benefit and, as such, Medicaid reimbursement for the stay is not required.

    c. Expanded need. A person seeking LTSS eligibility who is receiving preventive level services authorized by EOHHS in accordance with Part 40-05-1 of this Title and has expanded needs or is determined by a treating health practitioner to have the need for in-home assistance to supplement skilled homecare or hospice services currently in place; or to extend to the period after skilled services have ended.

B. Expedited eligibility benefits are limited to maximum of: twenty (20) hours weekly of personal care/homemaker services; three (3) days weekly of adult day services; and/or limited skilled nursing services based upon level of need. Upon approval of Medicaid LTSS, the beneficiary qualifies to receive full coverage. The following also apply:

1. Limited duration – The expedited eligibility benefit package is available for up to ninety (90) days or until the eligibility decision is rendered, whichever comes first.

2. Exemptions – There is no PETI conducted in conjunction with expedited eligibility and, as a consequence, no required contribution toward the cost of care during the ninety (90) coverage period. Retroactive eligibility is not

available, though costs incurred and unpaid for Medicaid covered services prior to the LTSS application filing date are considered when determining eligibility for full coverage.

3. Restrictions – Under the terms of the State's Section 1115 demonstration waiver, expedited eligibility is not available for LTSS in a health institution setting.

1.11 Roles and Responsibilities

A. Persons seeking LTSS Medicaid eligibility must meet the general requirements that apply program-wide related to residency, citizenship, and cooperation, among others.

1. Agency responsibilities – The EOHHS is responsible for determining Medicaid LTSS eligibility, authorizing services, the appropriate level of care planning and service coordination, as dictated by setting, and enrollment in service delivery option of choice. Under the terms of interagency agreements, the DHS and BHDDH have been authorized to determine all or some aspects of LTSS eligibility as an agent of the EOHHS.

2. Applicant Responsibilities – Beneficiaries determined eligible through this pathway must provide accurate and timely information and the consent necessary for EOHHS, or its agent(s), to obtain the health care information required for the clinical eligibility determination.

1.12 Severability

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