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TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 40 – MEDICAID FOR ELDERS AND ADULTS WITH DISABILITIES

SUBCHAPTER 15 – WORKING ADULTS WITH DISABILITIES ~~DISABLED WORKING ADULTS~~

Part 1 – Working Adults with Disabilities

1.1 Scope and Applicability

A. One of the principal objectives of health and human services policymakers is to support Medicaid-eligible adults with disabilities who work by enabling them to obtain or maintain the coverage they need to retain their independence and optimize their health. Toward this end, an array of State and Federal laws and Regulations have been adopted that establish special provisions for disregarding all or a portion of the earned income of adults with disabilities who work. The State also provides Medicaid coverage for an array of employment services and supports to assist beneficiaries with disabilities who are employed. This Part describes the eligibility pathways that are available to adults with disabilities who are working.

B. In addition, the State has taken the options under Federal law to create ~~a~~ two (2) ~~unique~~ eligibility pathways – known as the Sherlock Plan and the Ticket to Work Program – which enable~~s~~ working adults with disabilities who are otherwise Medicaid ineligible or unable to obtain needed employment supports to buy into the program at a low monthly cost.

~~B.~~ To qualify for the Medicaid special income provisions afforded by the Sherlock Plan or the Ticket to Work Program, a person must be determined to have a disability by a Federal or State government entity or appropriately designated contractual agent of the State in accordance with the standards set forth in Subchapter 05 Part 1 of this Chapter. Such entities include the U.S. Social Security Administration and the Medicaid~~l~~ Assessment and Review Team (MART) ~~and Office of Medical Review (OMR) within the Executive Office of Health and Human Services (EOHHS)~~described in Subchapter 05 Part 1 of this Chapter. Adults with disabilities who work and are seeking initial or continuing eligibility for Medicaid long-term services and supports (LTSS) may be subject to distinct "clinical/functional disability" criteria, as set forth in § 1.~~7~~8.1 of this Part. A beneficiary who meets these disability criteria and qualifies for these special income provisions is eligible for the full range of Medicaid covered employment services and supports.

C. Employment services and supports may also be available to adults with disabilities~~,~~ over age nineteen (19)~~,~~ who are eligible for Medicaid in accordance with the provisions of Part 30-00-1 of this Title in one (1) of the Medicaid Affordable Care Coverage (MACC) groups based on the modified adjusted gross income (MAGI) standard ~~– MAGI~~. Although a disability determination is not required, the scope of employment services and supports available may not be as extensive as through the other eligibility pathways for working adults with disabilities. Accordingly, seeking eligibility based on a formal determination of disability is an option, as set forth in herein in the following sections.

1.2 Legal Authority

A. ~~Federal Authorities~~This Part is promulgated pursuant to Federal authorities as follows:

1. Federal Law: Title XIX~~,~~ of the ~~Federal~~ U.S. Social Security Act~~,~~; 42 U.S.C. §§ 1396-1396w-7 ~~at: 42 U.S.C. §§ 1396a-k, 1902(a)(10)(A)(ii)(XIII) and (XV); 1916(g), 1905(v)(1); 1929(b)[2],1382(h), and 1619(a) and (b)~~;

2. ~~Federal Regulations: These Regulations hereby adopt and incorporate 42 C.F.R. §§ 435.120; 435.120(c) (1990); 435.121(b) (2013); and 447.55(a) (2014) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations and 20 C.F.R.§§ 416.260-269 (2023) and 416.976 (2023).~~

B. Applicable State ~~Authorities~~authority is derived from ~~:~~ R.I. Gen. Laws Chapters 40-6; 40-8; and 40-8.7.

1.3 Incorporated Materials

A. These regulations hereby adopt and incorporate 20 C.F.R. § 416.976 (2023) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these regulations.

B. These regulations hereby adopt and incorporate 20 C.F.R. §§ 416.1180-416.1182 (2023) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these regulations.

C~~A~~. These regulations hereby adopt and incorporate ~~42 C.F.R. § 435.120 (2023)~~42 C.F.R. § 435.120 (2023) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these regulations.

D~~B~~. ~~These regulations hereby adopt and incorporate 42 C.F.R. § 435.120(c) (1990) by reference, not including any further editions or amendments thereof, and only~~

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~~to the extent that the provisions therein are not inconsistent with these regulations~~ (2021~~3~~) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these regulations.

E. These regulations hereby adopt and incorporate 42 C.F.R. § 441.301 (2023) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these regulations.

F~~D~~. These regulations hereby adopt and incorporate 42 CFR § 447.55~~(a)~~ (~~2014~~2023) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these regulations.

~~E. These regulations hereby adopt and incorporate 20 C.F.R. § 416.976 (2023) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these regulations~~

A. As used herein, the following terms are defined as follows:

1. "Couple" means a person seeking initial or continuing eligibility for Medicaid and ~~his or her~~their spouse, regardless of whether the spouse is also an applicant or beneficiary unless otherwise indicated.

2. "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 (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)~~ designated as the single State agency for the Medicaid program.

3. "Long-Term Services and Supports" or "LTSS" means a spectrum of services covered by the Rhode Island Medicaid Program for persons with clinical and functional impairments and/or chronic illness 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.

4. "Medicaid Affordable Care Coverage" or "MACC" means the eligibility categories~~y~~ for individuals and families subject to the Modified Adjusted Gross Income (MAGI) standard identified in Part 30-00-1 of this Title.

5. "Medicaid health coverage" means the full scope of essential health care services and supports authorized under the State's Medicaid State Plan

and/or Section 1115 ~~demonstration w~~Waiver provided through an authorized Medicaid delivery system.

6. "Primary care essential benefits" means ~~and includes~~ 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 and providers. 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).

7. "Section 1115 Waiver" means the waiver authorized pursuant to § 1115 of the Social Security Act, 42 U.S.C. § 1315.

8. "Section 1619(a)" or "§ 1619(a)" means § 1619(a) of the Social Security Act, 42 U.S.C. § 1382h(a).

9. "Section 1619(b)" or "§ 1619(b)" means § 1619(b) of the Social Security Act, 42 U.S.C. § 1382h(b).

~~7~~~~8~~10. "Work supports" means the array of Medicaid services available to beneficiaries who have disabilities who need support to obtain or maintain employment. Depending on whether an LTSS level of care is required, these supports may include: pre-vocational services, education and training opportunities that build on strengths and interests, individually tailored and preference-based career planning, job development, job training, and job support that recognizes each person's employability and potential contributions to the labor market.

1.~~4~~5 SSI-Eligible Beneficiaries

A. Rhode Island provides Medicaid coverage to anyone who is eligible for and receiving Supplemental Security Income (SSI)~~,~~ based on a determination by the Federal Social Security Administration (SSA). The SSI program provides basic income to aged, blind, and disabled individuals who have little to no income and resources and who are unable to engage in substantial gainful activity. The State automatically enrolls SSI beneficiaries in Medicaid upon receipt of electronic notification from the SSA and must continue to provide coverage unless or until SSI status changes.

B. The SSA also determines whether working adults with disabilities receiving SSI qualify for continuing Medicaid eligibility after an SSI status change under ~~two (2)~~the special provisions in §~~§~~ 1619~~(~~a) or § 1619(b). ~~of Title XVI of the Social Security Act, the Federal law establishing the SSI program, codified at 42 U.S.C. 1382h.~~

1. Title XVI, §1619(a) of the Social Security Act, 42 USC 1382h(a) – "Special cash assistance" is available when an SSI beneficiary with a disability has gross earned income for the month that exceeds the amount ordinarily allowed to obtain or retain SSI eligibility. Both the special cash payments and Medicaid coverage are authorized in this instance under § 1619(a). Any beneficiary may qualify for § 1619(a) as early as his or her their second (2nd) month on the SSI rolls. To qualify, a person must:

   a. Continue to have a disabling impairment and meet all other non-disability requirements; and.

   b. Have been eligible for and received a regular SSI cash payment based on disability for a previous month within the current period of eligibility. The prerequisite month does not necessarily have to be the immediate prior month.

2. Title XVI, § 1619(b) of the Social Security Act, 42 U.S.C. 1382h(b) – SSI beneficiaries who have earnings too high for an SSI cash payment may be eligible for Medicaid if they meet certain requirements. To qualify for continuing Medicaid coverage under § 1619(b), a person must:

   a. Have been eligible for an SSI cash payment for at least one (1) month before the month when § 1619(b) is established;

   b. Continue to have a disabling impairment and, except for earnings, meet all other non-disability requirements;

   c. Need Medicaid benefits to continue to work; and

   d. Have gross earnings after excluding all work-related impairment expenses, blind work expenses, and earnings used to achieve an approved plan for self-support that are insufficient to replace SSI, Medicaid, and publicly funded attendant care services.

      (1) SSA uses a threshold amount to measure whether a person's earnings are high enough to replace his/her their SSI and Medicaid benefits. This threshold is based on the: amount of earnings which would cause SSI cash payments to stop in the person's State and average Medicaid expenses for persons who are blind or living with a disability in the State. The amount is recalculated annually and is available on the SSI program operations page titled: "SI 02302.200 Charted Threshold Amounts" and is available at: https://secure.ssa.gov/poms.nsf/lnx/0502302200published by the SSA.

      (2) If an SSI beneficiary has gross earnings higher than the threshold amount, SSA calculates an individual threshold amount, taking into account:

(AA) Impairment-related work expenses;

(BB) Blind work expenses;

(CC) A plan to achieve self-support; or

(DD) The value of any personal attendant services that are publicly funded through the DHS Office of Rehabilitative Services; and

(EE) Medical expenses above the average State amount or, if higher, the person's actual medical expenses.

C. The respective roles and responsibilities of the State and beneficiaries eligible for continuing Medicaid coverage through ~~Title XVI §§§~~ 1619(a) or § 1619(b) ~~of the Social Security Act, 42 U.S.C. 1382h~~ are as follows:

1. State

a. Benefits. The State must ensure that all required primary care essential benefits and any necessary work supports covered under the Medicaid State Plan or Section 1115 ~~demonstration w~~Waiver are available to members of ~~this~~ these coverage group~~s~~ on a timely basis.

b. Continuing eligibility. All SSI Medicaid-eligible beneficiaries are auto-renewed unless or until the State receives notification of termination of SSI. The State must evaluate whether Medicaid eligibility is available in all other coverage categories before initiating the termination process in accordance with Part 40-00-2 of this Title ~~§ 00-2.6.3(A)(3) of this Chapter~~.

2. Applicants/Beneficiaries

a. Applicants and beneficiaries must provide timely, accurate and complete information about any eligibility factors subject to change, including any changes in work circumstances or earnings that may affect continuing access to coverage through the pathways identified in this Part. In addition:

(1) Consent – At the time a Medicaid beneficiary eligible on the basis of SSI no longer qualifies for continuing coverage under ~~Title XVI~~ § 1619(a) or § 1619(b) ~~of the Social Security Act, 42 U.S.C. 1382h~~, the State may request that ~~he or she~~they provide the State with consent to retrieve and review any information not currently on record pertaining to the eligibility factors subject to change through electronic data matches conducted through the State's eligibility

system. Once such consent is provided, the Medicaid agency may retrieve and review such information when conducting all subsequent eligibility determinations and annual renewals.

(2) Duty to Report – Medicaid beneficiaries are required to report changes in eligibility factors to the Medicaid agency within ten (10) days from the date the change takes effect. Self-reports are permitted through the eligibility system consumer self-service portal as well as in person, via fax, or mail. Flexibility in reporting is allowed when a beneficiary changes work status and employers do not provide timely documentation of such changes.

1.~~5~~6 Community Medicaid Eligibility for Low-income Elders and Adults with Disabilities (EAD)

A. Working adults with disabilities who do not qualify for SSI due to excess income may be eligible for initial or continuing Medicaid coverage through the EAD pathway pursuant to Subchapter 05 Part 1 of this ~~Title~~ Chapter or as medically needy under Part Subchapter 05 Part 2 of this Chapter. All EAD beneficiaries are entitled to primary care essential benefits and any necessary work supports covered under the Medicaid State Plan or Section 1115 ~~Demonstration~~ Waiver.

B. Working adults with disabilities may obtain initial or continuing eligibility through the following:

1. Work-related protections – Some applicants/beneficiaries may qualify for several of the same special provisions available to applicants and beneficiaries that reduce or protect earned income set forth in Subchapter 00 Part 3 of this Chapter, including but not limited to:

   a. PASS Disregard – Income, whether earned or unearned, of a person who is blind or living with a disabling impairment may be excluded if such income is needed to fulfill a Plan for Achieving Self-Support (PASS). This exclusion does not apply to applicants who are age sixty-five (65) or older, unless the applicant was receiving SSI or State Supplemental Payment (SSP) before reaching that age. For additional information on the PASS, see the Federal SSI Regulations at 20 C.F.R. §§ 416.1180 through 416.1182.

   b. Impairment-Related Work Expenses – Earned income used by a person with disabilities to pay impairment-related work expenses is disregarded. For the disregard to apply, the person must have a disability and be under age sixty-five (65) or have been eligible for

and received SSI based on disability for the month before reaching age sixty-five (65). In addition, the following must be met:

(1) The severity of the impairment must require the person to purchase or rent items and services in order to work;

(2) The expense must be reasonable given the nature of the disability or impairment and the type of employment, as determined by the agency;

(3) The expense must be paid in cash (including checks, money orders, credit cards and/or charge cards) by the person and must not be reimbursable from another source, such as Medicare or private insurance; and

(4) The payment for the expense must be made in a month the person receives earned income and anticipated work or worked and used the services or the item purchased, or the person must be working and pay the expense before earned income is received.

(5) Impairment-related work expenses that may qualify for this disregard are described in Federal SSI Regulations at 20 C.F.R. § 416.976.

b. Student Child Earned Income Exclusions (SEIE) – For a student under age twenty-two (22) or a person who is blind or disabled and regularly attending school, a set amount of earned income per month up to a yearly maximum may be excluded. The Federal government determines the monthly and maximum amounts based on variety of factors and adjusts the figures annually to reflect increases in the cost of living. The amount of the exclusion is set by the Federal government and updated on an annual basis, as described. The amount of the exclusion is located in Part 40-00-3 of this Title § 00-3.1.7(A)(6) of this Chapter.

c. Work-Related Expenses of Blind Persons – Earned income used to meet any expenses reasonably attributable to the earning of the income by a person who is blind and under age sixty-five (65) or received SSI as a blind person for the month before reaching the age of sixty-five (65). Further, expenses may be disregarded if the person has an approved plan for self-supporta (PASS). The amounts must be reasonable and not exceed the earned income of the blind person or a blind spouse. See references on PASS, including types of expenses that qualify for this disregard in Part 40-00-3 of this Title § 00-3.3.2(A)(3) of this Chapter.

d. RI Works Under a PASS. In accordance with RI Works Regulations, RI Works payments administered by the RI Department of Human Services under a PASS are excluded. However, RI Works payments ~~unless~~ not excluded under a PASS~~,~~ are countable income.

2. Community Medicaid Medically Needy – Coverage is available to elders and ~~persons~~ adults with disabilities with high medical expenses who have income above the EAD countable income limit of one hundred percent (100%) of the FPL, but otherwise meet all of the general eligibility requirements for Medicaid as set forth in Part 40-05-1 of this Title ~~§ 05-1.9 of this Chapter~~. Work related disregards identified in § 1.~~5~~6(B) of this Part are taken into account when determining financial eligibility for the Community Medicaid medically needy pathway ~~Medically needy~~. Beneficiaries have the option of consulting with an agency eligibility specialist when considering whether the Medically needy pathway provides them with the level Medicaid benefits and coverage they need while continuing to work. The Sherlock or Ticket to Work pathway may be a more appropriate option in some instances due to the following:

   a. Scope of coverage. Until excess income over the eligibility limit has been exhausted during the six (6) month spenddown period, beneficiaries who choose ~~this~~ the medically needy pathway are responsible for paying out-of-pocket for all health care expenses that are not covered by a third ~~(3rd)~~ party such as Medicare or a commercial plan, including for any necessary work supports. Expenses associated with third ~~(3rd)~~ party coverage, such as premiums, co-pays and deductibles do count toward the spenddown. See Subchapter 05 Part 2 of this Chapter on the Medically needy eligibility pathway for additional information.

   b. Continuing eligibility. Renewal of Medically needy eligibility and the initiation of another spenddown period may require a redetermination of countable income through the integrated eligibility system (IES).

3. Sherlock Plan for Working People with Disabilities and the Ticket to Work Program – Applicants who qualify for Medicaid coverage under more than one (1) eligibility pathway may choose the ~~one (1)~~pathway most suited to their unique needs. Accordingly, the Sherlock or Ticket to Work eligibility pathway~~s~~ ~~is~~are also available for applicants and beneficiaries who qualify through the medically needy pathway but are unable to obtain the supports they need through a spenddown.

C. The respective roles and responsibilities of the State and applicants/beneficiaries with disabilities who are working and seeking initial or continuing Medicaid coverage through the EAD pathway are set forth in Part 40-05-1 of this Title ~~§ 05-1.5 of this Chapter~~.

1.~~6~~7 Medicaid Affordable Care Coverage (MACC) MAGI-~~e~~Eligible Adults

A. Working adults with disabilities who are eligible through the Medicaid Affordable Care Coverage (MACC) groups in: the ACA adult expansion pathway for persons ages nineteen (19) through sixty-four (64); the parent/caretaker pathway; or pregnant ~~women~~ people pathway may obtain the work-related services and supports they need through their Medicaid managed care plan or, if enrolled in fee-for-service or a RIte Share approved employer-sponsored insurance plan, through certified Medicaid providers. Pre-authorization of services by the plan or Medicaid provider is required unless a disability determination has been made by the ~~EOHHS~~ Medicaid Assessment and Review Team (MART) or another government entity such as the Federal Social Security Administration (SSA).

B. There are no special disregards for working adults with disabilities available through the MAGI methodology for determining income eligibility. However, MACC eligible beneficiaries, including those who qualify for Medicaid LTSS, are not liable under Federal law to pay a share of the costs of their care.

C. If earnings from work increase income above the applicable MACC group eligibility limit, applicants and beneficiaries must seek coverage through an alternative Medicaid eligibility pathway that uses the SSI methodology and requires a formal disability determination by the MART, unless such a determination has already been made by another government authority including the SSA. The IES automatically evaluates persons for these alternative forms of eligibility if they do not qualify for MACC group coverage due to excess income. Depending on a person's income and resources and level of need, the available pathways are as follows:

1. Community Medicaid (Non-LTSS) – The ~~two~~ three (~~2~~3) alternative eligibility pathways for MACC eligible working adults with disabilities who are not seeking or do not ~~require or~~ meet the level of care criteria for the full scope of Medicaid long-term services and supports are: Community Medicaid EAD, including the Medically needy pathway as specified in Parts 40-05-1 and 40-05-2 of this Title ~~§ 05-1.5 of this Chapter~~ and above, ~~and~~ the Sherlock pathway, as set forth in § 1.~~8~~9 of this Part, and the Ticket to Work Program as set forth in § 1.10 of this Part. ~~.~~ The SSI work-related income disregards indicated in § 1.45(B)(1) of this Part are applied and a disability determination by the MART or SSA is required.~~;~~

2. Medicaid LTSS – MAGI-eligible working adults with disabilities who meet the level of care requirements for Medicaid long-term services must be determined disabled to obtain work-related services and supports. If income exceeds the MACC group limit due to earnings from work, eligibility may continue to be available through the LTSS/SSI-related pathways including LTSS Medically needy (§ 1.~~7~~8 of this Part), ~~or~~ the Sherlock pathway (§ 1.~~8~~9 of this Part), or the Ticket to Work Program (§

1.10 of this Part). The SSI work-related income disregards indicated in § 1.54(B)(1) of this Part are applied and a disability determination by the MART or SSA is required.

1.78 Medicaid Long-term Services and Supports (LTSS)

1.87.1 Eligibility Determination Process

A. Adults with disabilities who are seeking LTSS – both current Medicaid beneficiaries and new applicants – who do not qualify for MACC group LTSS are evaluated for eligibility across the pathways set forth in §Part 50-00-1.8 of this Title using the SSI methodology. Accordingly, they may qualify for the work-related income disregards identified in § 1.54(B)(1) of this Part (above) in the eligibility determination process. If a beneficiary is eligible for multiple LTSS options, the beneficiary may choose their eligibility group.

B. In accordance with Part 50-00-5 of this Title, all applicants/beneficiaries seeking LTSS must meet clinical/functional level of care criteria. A separate disability determination by the SSA or MART is not required for applicants/beneficiaries who meet the clinical/functional level of care criteria for Medicaid LTSS unless the person is seeking LTSS through the Sherlock Plan or Ticket to Work Program.

1.87.2 Service Plan

A. All Medicaid LTSS beneficiaries must have a service plan that ties benefits to their functional and clinical needs. If employment supports are needed, the role of work, if any, and any associated employment supports must be a component of this plan. For LTSS beneficiaries choosing home and community-based services, the service plan must reflect the decisions they make about their health goals established in the person-centered planning process set forth in 42 C.F.R. § 441.725301 and in Part 50-10-1 of this Title. The development of a service plan is guided by agency representatives as the components may vary depending on the type of a person's disability, program requirements, and associated provisions under the Section 1115 wWaiver and Medicaid State Plan. Accordingly, specific guidance is provided on this process. In response to the novel Coronavirus Disease (COVID-19), EOHHS will postpone in-person person centered planning.

1.78.3 Cost of Care

A. In accordance with Federal requirements, under the State's Medicaid State Plan and Section 1115 wWaiver, all LTSS Medicaid beneficiaries eligible based on the SSI methodology who can afford to do so must pay a portion of income toward the cost of their care. A beneficiary's liability for the cost of care is calculated in the post-eligibility treatment of income process in accordance with Part 50-00-8 of this Title and is based on gross monthly income – earned and unearned – less

certain deductions or "allowances." To encourage LTSS beneficiaries who have disabilities to work, there are special allowances which require the State to exclude some or all of the beneficiary's earned income when determining the amount available to be applied toward the cost of care. In addition, under the Sherlock Plan and Ticket to Work Program, a beneficiary may opt to pay a monthly premium instead of a cost of care.

B. A beneficiary's liability may increase or decline when there are changes in income. The State provides timely notice of any changes in beneficiary liability that may result at least ten (10) days before the start of the month when the change takes effect.

~~**1.7.4 LTSS Options and Responsibilities**~~

A. The Sherlock Plan for Working People with Disabilities is an SSI-related eligibility pathway for working adults with disabilities age sixty-five (65) and older established pursuant ~~to the Balanced Budget Act of 1997 (~~42 U.S.C. § 1396a(a)(10)(ii)(XIII)~~)~~ and R.I. Gen. Laws ~~at~~ § 40-8.7-1 et seq. The State law is based on the option under the Federal law to establish a Medicaid eligibility pathway for adults with disabilities who are ~~either~~ unable to afford or obtain health coverage and/or the services and supports they need to work.

B. Adults with disabilities eligible through the Sherlock pathway are entitled to the full scope of Medicaid benefits and home and community-based services and supports necessary to facilitate and/or maintain employment. This is the same scope of coverage available to all Medicaid-eligible adults with disabilities who work, without regard to eligibility pathway. The special provisions in the SSI methodology established in Subchapter 00 Part 3 of this Title, and reiterated herein at § 1.45~~,~~ of this Part, may apply. ~~To ensure continuation of EOHHS' eligibility for enhanced Federal funding, EOHHS will continue eligibility for individuals that may have a change in employment status that occur during the Federal novel Coronavirus Disease (COVID-19) declaration of emergency.~~ Changes in employment ~~after the termination of the Federal novel coronavirus declaration of emergency will~~ follow the provisions in § 1.98.45.

C. The Sherlock eligibility pathway is open to adults with disabilities who are working and seeking:

1. Non-LTSS Medicaid primary care essential benefit coverage ~~with HCBS services including employment supports~~; or

2. Medicaid LTSS coverage including integrated employment supports.

D. To qualify through the Sherlock pathway, a person must be determined disabled by a State or Federal government authority using the criteria established for the SSI program except for the provisions related to substantial gainful activity.

1. General eligibility requirements –To be Sherlock-eligible, a person must:

   a. Meet the non-financial eligibility requirements set forth in Part 10-00-3 of this Title~~; and:~~

   b. Be ~~between nineteen (19) and sixty-four (64) years of age~~age sixty-five (65) or older; and

   c. Have proof of active, paid employment such as a pay stub or current quarterly U.S. Internal Revenue Service (IRS) tax statement (for those who are self-employed).

2. Financial eligibility – Applicants for Sherlock eligibility are subject to the ~~requirements~~ SSI methodology for counting income and resources set forth in Subchapter 00 Part 3 of this ~~Title~~Chapter. The following income and resource standards apply:

   a. Income. Countable earned net income must be no greater than two hundred fifty percent (250%) of the FPL. Countable earned net income is defined as the total of earned income remaining after all SSI-related disregards are applied; and

   b. Resources. Total countable resources must be no greater than ten thousand dollars ($10,000.00) (individual) or twenty thousand dollars ($20,000.00) (couple). Medical savings accounts, retirement accounts, or accounts determined to be for the purposes of maintaining independence are not counted as a resource; approved items that are necessary for a person to remain employed are also not counted as a resource (such as a wheelchair accessible van).

3. Retroactive coverage – As an SSI-related coverage group, applicants may be eligible for up to ninety (90) days of retroactive coverage. Eligibility for retroactive coverage is determined in accordance with Subchapter 05 Part 2 of this ~~Title~~ Chapter once the premium or cost of care requirements set forth below in § 1.8.2 of this Part have been met.

~~1.8.1 Access to Employer-Based Health Insurance~~

A. Depending on their gross countable income from all sources, both LTSS and non-LTSS Sherlock beneficiaries may be required to pay a share of the cost of coverage. Non-LTSS Sherlock beneficiaries subject to a cost share are required to pay a premium; LTSS Sherlock beneficiaries who have a cost share have the choice of paying a ~~portion of income~~cost of care ~~-~~or a premium.

   1. Sherlock Premium – To calculate a premium, the earned income of the Sherlock beneficiary and ~~his or her~~their spouse, if applicable, are added together and then all SSI-related disregards are applied. The remaining

earned income is added to the unearned income of the beneficiary or couple and are assigned a premium as follows:

a.

Income	Monthly Premium
Less than 150% FPL	No premium
At least 150% and less than 185% FPL	$ 61.00
At least 185% and less than 200% FPL	$ 77.00
At least 200% and up to 250% FPL	$ 92.00

~~based on the buy-in payment rates in Part 30-05-3 of this Title, entitled RIte Share Premium Assistance Program.~~

~~A~~b. Premiums must be paid in full before retroactive coverage for allowable health care expenses is made available by the State.

~~b~~c. Sherlock beneficiaries may deduct premium amounts from the total amount of any unpaid medical bills in the retroactive coverage eligibility period.

2. LTSS Sherlock ~~beneficiary liability~~Cost of Care – The State bases its calculation of a LTSS Sherlock beneficiary's liability for the cost of care in accordance with the post-eligibility treatment of income rules set forth in Part 50-00-8 of this Title. A LTSS Sherlock beneficiary is entitled to all the allowances set forth therein when determining the amount of income available to pay toward the cost of care.

3. Sherlock LTSS beneficiary choice – The State calculates both the monthly premium and the beneficiary liability for Sherlock LTSS beneficiaries. An LTSS eligibility specialist is responsible for informing the beneficiary of the premium versus beneficiary liability costs and assisting the beneficiary in making an appropriate choice. The State does not impose or collect a cost share until a Sherlock LTSS beneficiary has been so informed and made a choice. Coverage may not be delayed or denied pending the beneficiary's decision.

~~**1.8.3 Cost Share Collection Methods**~~

~~A. Sherlock beneficiaries are required to make monthly cost share payments, without regard to type. A Sherlock LTSS beneficiary opting to pay~~

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beneficiary liability – if any – other than a premium, must pay his/her portion each month in accordance with the provisions set forth in Part 50-00-8 of this Title

A. Absent a hardship exemption, EOHHS will terminate eligibility after a beneficiary fails to pay their premium for ninety (90) days.

B. The provisions governing non-payment of beneficiary liability are set forth in the LTSS post-eligibility treatment of income rule contained in Part 50-00-8 of this Title.

1.9.3 Hardship Exemption

A. If circumstances arise that prevent a beneficiary eligible through the Sherlock pathway from paying their premium in a given month, the beneficiary may apply for a hardship exemption.

1. An individual is eligible for a hardship exemption if they meet any of the following criteria in the month for which they are applying:

    a. They were unhoused

    b. They were evicted in the past six (6) months or were facing eviction or foreclosure

    c. They received a shut-off notice from a utility company

    d. They recently experienced domestic violence

    e. They recently experienced the death of a close family member

    f. They experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to their property

    g. They filed for bankruptcy in the last six (6) months

    h. They had medical expenses they could not pay in the last 24 months that resulted in substantial debt

    i. They experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member

    j. They expect to claim a child as a tax dependent who has been denied coverage in Medicaid and Children's Health Insurance Program (CHIP), and another person is required by court order to provide medical support to the child and that person does not do so

    k. They experienced other extenuating circumstances that inhibited their ability to pay their premium

2. If the hardship exemption request is approved the premium invoice will be cleared.

3. If the hardship exemption request is denied, the beneficiary will be required to pay the premium.

~~**1.8.4 Non-Payment Sherlock Cost Share**~~

A. A Sherlock beneficiary who loses employment may retain eligibility for up to four (4) months by continuing to pay the applicable cost share, whether a premium or beneficiary liability payment. If the person is still unemployed at the end of the four (4) month period, Sherlock eligibility is terminated. Prior to taking this action, the State evaluates the Sherlock beneficiary for all other forms of Medicaid eligibility as well as for coverage for a commercial plan through HSRI, the State's health insurance marketplace.

B. A person who is no longer eligible for Medicaid through the Sherlock pathway may retain approved medical savings accounts and retirement account assets in the amount held on the last full day of eligibility. These medical savings account and/or retirement account assets will be considered non-countable assets for purposes of Medicaid eligibility under any other coverage group. Paper documentation must be provided verifying the balances of these accounts as of the last date of Sherlock eligibility if it is to be disregarded for other forms of Medicaid coverage.

1.~~8~~9.5~~6~~ Available Services

A. Services include the full scope of categorical Medicaid benefits, including home and community-based services if eligible for LTSS, including personal care services provided through an agency or through a self-directed program~~,~~ and services needed to facilitate and/or maintain employment, as described in Chapter 50 of this Title. ~~The applicant/beneficiaries' s~~Services are coordinated through the appropriate unit in EOHHS, DHS or BHDDH or a contractual designee of the agency. ~~Long-term care services and supports are listed in Part 50-00-1 of this Title entitled, Medicaid Long-Term Services and Supports: Overview and Eligibility Pathways.~~

B. Services to maintain and support employment are determined when developing a service plan, or through an assessment of need utilizing a state approved assessment instrument or an EOHHS approved prior authorization plan. Authorized personal care services may be provided in the home, workplace or other necessary setting (such as a physician office).

1.10 The Ticket to Work Program

A. The Ticket to Work Program is an SSI-related eligibility pathway for working adults with disabilities established pursuant to ~~the Ticket to Work and Work~~

~~Incentives Improvement Act of 1999, Pub. Law 106-170~~ 42 USC § 1396a(a)(10)(A)(ii)(XV) and RI Gen. Laws ~~at~~ § 40-8.7-1 ~~et seq.~~ The State law is based on the option under the Federal law to establish a Medicaid eligibility pathway for adults with disabilities who are ~~either~~ unable to afford or obtain health coverage and/or the services and supports they need to work.

B. Adults with disabilities eligible through the Ticket to Work Program are entitled to the full scope of Medicaid benefits and home and community-based services and supports necessary to facilitate and/or maintain employment. This is the same scope of coverage available to all Medicaid-eligible adults with disabilities who work, without regard to eligibility pathway. The special provisions in the SSI methodology established in Subchapter 00 Part 3 of this Title, and reiterated herein at § 1.5 of this Part, may apply.

C. The Ticket to Work eligibility pathway is open to adults with disabilities who are working and seeking:

1. Non-LTSS Medicaid primary care essential benefit coverage ~~with HCBS services including employment supports~~; or

2. Medicaid LTSS coverage including integrated employment supports.

D. To qualify through the Ticket to Work pathway, a person must be determined disabled by a State or Federal government authority using the criteria established for the SSI program except for the provisions related to substantial gainful activity.

1. General eligibility requirements –To be Ticket to Work-eligible, a person must:

a. Meet the non-financial eligibility requirements set forth in Part 10-00-3 of this Title ~~and:~~;

b. Be age between the ages of sixteen (16) and sixty-four (64); and

c. Have proof of active, paid employment such as a pay stub or current quarterly U.S. Internal Revenue Service (IRS) tax statement (for those who are self-employed).

~~3.~~ 2. Financial eligibility – Applicants for Ticket to Work eligibility are subject to the SSI methodology for counting income and resources set forth in Subchapter 00 Part 3 of this Chapter. However, there are no income or resource limits for the program. Nonetheless, income and resources must be reported for the purposes of calculating cost sharing amounts and, if applicable, determining if disqualifying transfers of assets have been made according to Part 50-00-6 of this Title.

3. Retroactive coverage – As an SSI-related coverage group, applicants may be eligible for up to ninety (90) days of retroactive coverage. Eligibility for

retroactive coverage is determined in accordance with Subchapter 05 Part 2 of this Title once the premium or cost of care requirements set forth below in § 1.10.1 of this Part have been met.

1.10.1 Types of Cost Sharing

A. Depending on their gross countable income from all sources, both LTSS and non-LTSS Ticket to Work beneficiaries may be required to pay a share of the cost of coverage. Non-LTSS Ticket to Work beneficiaries subject to a cost share are required to pay a premium; LTSS Ticket to Work beneficiaries who have a cost share generally have the choice of paying a portion of income or premium.

1. Ticket to Work Premium – ~~Premiums are determined based on family income, beginning at one hundred and fifty percent (150%) FPL on a sliding fee scale, and can be no more than five percent (5%) of the total family income. Premiums are as follows:~~To calculate a premium, the earned income of the Ticket to Work beneficiary and their spouse, if applicable, are added together and then all SSI-related disregards are applied. The remaining earned income is added to the unearned income of the beneficiary or couple and are assigned a premium as follows:

Income	**Monthly Premium**
Less than 150% FPL	No premium
At least 150% and less than 185% FPL	$ 61.00
At least 185% and less than 200% FPL	$ 77.00
At least 200% and less than 250% FPL	$ 92.00
At least 250% and less than 300% FPL	$ 110.00
At least 300% and less than 350% FPL	$ 130.00
At least 350% and less than 400% FPL	$ 150.00
At least 400% and less than 450% FPL	$ 170.00

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At least 450% and less than 500% FPL	$ 190.00
At least 500% and less than 550% FPL	$ 210.00
At least 550% and less than 600% FPL	$ 230.00
At least 600% and less than 650% FPL	$ 250.00
At least 650% and less than 700% FPL	$ 270.00
At least 700% and less than 750% FPL	$ 290.00
At least 750% and less than 800% FPL	$ 310.00
At least 800% FPL and less than 850% FPL	$ 330.00
At least 850% FPL and less than 900% FPL	$ 350.00
Greater than 900% FPL	$ 370.00

b. Premiums must be paid in full before retroactive coverage for allowable health care expenses is made available by the State.

c. Ticket to Work beneficiaries may deduct premium amounts from the total amount of any unpaid medical bills in the retroactive coverage eligibility period.

2. LTSS Ticket to Work beneficiary liability – The State bases its calculation of a LTSS Ticket to Work beneficiary's liability for the cost of care in accordance with the post-eligibility treatment of income rules set forth in Part 50-00-8 of this Title. A LTSS Ticket to Work beneficiary is entitled to all the allowances set forth therein when determining the amount of income available to pay toward the cost of care. The beneficiary liability option is available only if the beneficiary's countable income is less than or equal to the private pay rates established in Part 50-00-2 of this Title.

3. Ticket to Work LTSS beneficiary choice – The State calculates both the monthly premium and the beneficiary liability, if applicable, for Ticket to Work LTSS beneficiaries. An LTSS eligibility specialist is responsible for informing the beneficiary of the premium versus beneficiary liability costs and assisting the beneficiary in making an appropriate choice if they qualify for both options. The State does not impose or collect a cost share until a Ticket to Work LTSS beneficiary has been so informed and made a choice. Coverage may not be delayed or denied pending the beneficiary's decision.

1.10.2 Non-Payment Ticket to Work Cost Share

A. Absent a hardship exemption, EOHHS will terminate eligibility after a beneficiary fails to pay their premium for ninety (90) days.

B. The provisions governing non-payment of beneficiary liability are set forth in the LTSS post-eligibility treatment of income rule contained in Part 50-00-8 of this Title.

1.10.3 Hardship Exemption

A. If circumstances arise that prevent a beneficiary eligible through the Ticket to Work pathway from paying their premium in a given month, the beneficiary may apply for a hardship exemption.

1. If the hardship exemption request is approved for a given month, ~~any existing Ticket to Work~~that month's premium invoice~~(s)~~ will be cleared.

2. If the hardship exemption request is denied, the beneficiary will be required to ~~continue~~ pay~~ing~~ the~~ir~~ premium.

1.10.4 Loss of Employment or Eligibility

A. A Ticket to Work beneficiary who loses employment may retain eligibility for up to four (4) months by continuing to pay the applicable cost share, whether a premium or beneficiary liability payment. If the person is still unemployed at the end of the four (4) month period, Ticket to Work eligibility is terminated. Prior to taking this action, the State evaluates the Ticket to Work beneficiary for all other forms of Medicaid eligibility as well as for coverage for a commercial plan through HSRI, the State's health insurance marketplace.

B. A person who is no longer eligible for Medicaid through the Ticket to Work pathway may retain approved medical savings accounts and retirement account assets in the amount held on the last full day of eligibility. These medical savings account and/or retirement account assets will be considered non-countable assets for purposes of Medicaid eligibility under any other coverage group. Paper documentation must be provided verifying the balances of these accounts as of

the last date of Ticket to Work eligibility if it is to be disregarded for other forms of Medicaid coverage.

1.10.5 Available Services

A. Services include the full scope of categorical Medicaid benefits, including home and community-based services if eligible for LTSS, including personal care services provided through an agency or through a self-directed program~~,~~ and services needed to facilitate and/or maintain employment, as described in Chapter 50 of this Title. ~~The applicant/beneficiaries' s~~Services are coordinated through the appropriate unit in EOHHS, DHS or BHDDH or a contractual designee of the agency. ~~Long-term care services and supports are listed in Part 50-00-1 of this Title entitled, Medicaid Long-Term Services and Supports: Overview and Eligibility Pathways.~~

service plan, or through an assessment of need utilizing a state approved assessment instrument or an EOHHS approved prior authorization plan. Authorized personal care services may be provided in the home, workplace or other necessary setting (such as a physician office).