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TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 40 – MEDICAID FOR ELDERLY AND ADULTS WITH DISABILITIES

SUBCHAPTER 05 – COMMUNITY MEDICAID

Part 1 – Community Medicaid

1.1 Overview

The IHCC groups established in this section provide the principal Medicaid non-Long Term Services and Supports (LTSS) eligibility pathways for elders and adults with disabilities who have Supplemental Security Income (SSI), an SSI characteristic, and/or meet special program specific requirements. The medically needy (MN) eligibility pathway for all populations seeking non-LTSS Medicaid coverage is also included in this section. The State uses the term “Community Medicaid” to distinguish Integrated Health Care Coverage (IHCC) group members from Medicaid LTSS beneficiaries eligible using SSI financial eligibility requirements.

1.2 Authority

Legal authority for the IHCC groups is established in R.I. Gen. Laws, the Medicaid State Plan, the State’s § 1115 demonstration waiver and various provisions of Title XIX of the Social Security Act, 42 U.S.C. § 1396a and Code of Federal Regulations (CFR). State law establishing the IHCC group that expands eligibility to low-income elders and adults with disabilities (referred hereinafter as “EAD”) with income up to and including one hundred percent (100%) of the Federal Poverty Level (FPL) is located in R.I. Gen. Laws Chapter 40-8.5. Many of the core eligibility requirements associated with this group, including those pertaining to MN eligibility, pre-date both this law’s enactment and federal approval of the State’s 1115 waiver as extended in 2014 and, are dispersed in various other provisions of R.I. Gen. Laws Chapter 40-8 rather than in a single statute.

1.3 Scope and Purpose

This purpose of this rule is to establish and describe the Community Medicaid IHCC groups and the requirements for determining Medicaid eligibility, effective on and after the effective date of this rule. The summary table below shows each of these groups and the agency authorized to determine eligibility or the basis for eligibility:

Community Medicaid Eligibility Pathways	
IHCC Group	Agency Responsible for Determining Eligibility
Low-income Elders and Adults with Disabilities (EAD)	EOHHS
SSI Recipients	Social Security Administration (SSA)
SSP Recipients	SSA and EOHHS
Pickle Amendment	EOHHS
§ 1619(a) Employed Adults with Disabilities	SSA
§ 1619(b) Medicaid While Working	SSA
Protected Surviving Spouses	EOHHS
Adult Children with Disabilities	EOHHS
Divorced/Surviving Spouses with Disabilities	SSA
SSP Recipients, 12/73	EOHHS
Divorced/Surviving Spouses with Disabilities – Actuarial Changes	SSA
Breast and Cervical Cancer Screening and Treatment	Department of Health (DOH)
Refugee Medicaid Assistance (RMA)	EOHHS
Sherlock Plan	EOHHS

1.4 Definitions

A. For the purposes of this section, the following definitions apply:

1. "Adult dependent child" means an unmarried person eighteen (18) years of age or older who has a disabling impairment that began before age twenty-two (22) that is collecting disability related benefits from the U.S. Social Security Administration (SSA).
2. "Applicant" means the person seeking initial or continuing eligibility for Medicaid.
3. "Community Medicaid eligibility standards" means the income and resource standards used as the basis for determining initial and continuing Medicaid eligibility for each coverage group included in this section.
4. "Deemed income" means income attributed to another person whether or not the income is actually available to the person to whom it is deemed.
5. "Deemor" means a person whose income and/or resources are subject to deeming. Such individuals include non-applicant parents and spouses and sponsors of non-citizens.
6. "Non-applicant" or "NAPP" means a person whose finances are considered for deeming purposes although is not seeking or is unqualified for Medicaid.
7. "Parent" means a natural or adoptive father or mother living in the same household as the eligible child.

1.5 Eligibility for Elders and Adults with Disabilities

1.5.1 Scope and Purpose

This section identifies the chief eligibility pathways for persons sixty-five (65) and older and nineteen (19) to sixty-four (64) who are living with a disabling impairment – adults with disabilities.

1.5.2 EAD Eligibility Pathway – Low-income Elders and Adults with Disabilities

- A. Under the Social Security Act, 42 U.S.C. § 1396(a) states have the option under the Medicaid State Plan of expanding eligibility to elders and adults with disabilities up to and inclusive of one hundred percent (100%) of the FPL. Rhode Island chose this option in 1999 and now refers to this categorically eligible expansion group by the acronym "EAD." The EAD coverage group has higher income and resource limits than the SSI program and serves, therefore, as the State's chief general eligibility pathway for anyone with an SSI characteristic who does not qualify for SSI benefits. Coverage group features are as follows:
 1. Eligibility Criteria – To qualify for Medicaid coverage through the EAD eligibility pathway, a person must meet the general eligibility requirements

related to residency, citizenship and cooperation set forth in § 1.9 of this Part and the following:

- a. Characteristic Requirements. A person must be without SSI and meet the characteristic requirements with respect to:
 - (1) Age. Sixty-five (65) and older; or
 - (2) Disability. Determined by the State's Medicaid Assessment and Review Team (MART) to meet the applicable SSI disability standards; or
 - (3) Blindness. Federal regulations preclude states that have expanded SSI-based eligibility to income above the SSI standard (at or below seventy-five percent (75%)) to treat blindness as a distinct eligibility characteristic. Accordingly, applicants who are blind and are ineligible for SSI or an SSI Protected Status are subject to a MART disability determination.
 - b. Financial Requirements. The person must meet income and resource standards for EAD eligibility based on the SSI methodology as follows:
 - (1) Income. Total countable income must be at or below one hundred percent (100%) of the FPL for the family size involved; and
 - (2) Resources. Total countable resources must not exceed four thousand dollars (\$4,000) for an individual and six thousand dollars (\$6,000) for a couple.
2. Determination Process – The application review process evaluates all persons seeking Medicaid for eligibility through a MACC group using the MAGI standard. Anyone who self-reports a disabling impairment or who is sixty-five (65) or older is then evaluated for Community Medicaid eligibility through the pathways set forth in this section. Federal regulations at 42 C.F.R. § 435.404 require EOHHS to provide anyone determined eligible through multiple pathways to choose the coverage group that best suits their needs.
 3. Continuing Eligibility – With implementation of the State's integrated eligibility system(IES), EOHHS is instituting a modified passive renewal process. Beneficiaries are required to review and update a pre-populated form containing information obtained in their accounts and updated monthly or quarterly through electronic data matches about eligibility factors subject to change. Detailed provisions pertaining to the passive renewal process are set forth in [§ 00-2.7.2\(A\)\(5\)](#) of this Chapter. EOHHS

will postpone the processing of annual Medicaid eligibility renewals that fall during the novel Coronavirus Disease (COVID-19) declaration of emergency for sixty (60) days or until the termination of the COVID-19 declaration of emergency, whichever is longer. This includes the suspension of periodic data checks for unemployment, State Wage Information Collection Agency (SWICA), TALX (The Employment Verification System at HRSA) and other sources and suspension of quarterly post-eligibility verifications.

4. Agency Responsibilities – The EOHHS is responsible for overseeing the evaluation of applications for EAD eligibility, enrollment, and processing renewals. In addition, prior to ending Medicaid health coverage, the EOHHS must ensure that a review is conducted to determine whether eligibility exists through any other eligibility pathway. Other responsibilities are set forth in greater detail, as indicated, in other sections of this rule.

1.5.3 Medically Needy (MN) Eligibility Pathway

Medically needy eligibility is available to certain IHCC group members who do not need LTSS. (Different rules apply for LTSS eligibility as indicated in the Medicaid Code of Administrative Rules, Flexible Test of Income). Under the Rhode Island Medicaid State Plan, MN coverage is an option for elders and adults with disabilities, parents/caretakers, children and pregnant women. Adults nineteen (19) to sixty-four (64) in the MACC group do not qualify for MN coverage, and must therefore reapply through the Community Medicaid MN pathway. There is also a MN pathway for Refugee Medicaid Assistance as indicated in § 1.7.3. of this Part. See [Part 2](#) of this Subchapter for provisions related to the Community Medicaid MN pathway.

1.5.4 SSI and SSP Recipients and SSI Protected Status

- A. Federal law requires the states to provide Medicaid health coverage to SSI and SSP recipients. There are certain circumstances in which SSI recipients who lose or otherwise no longer qualify for full cash assistance benefits are afforded “protected status” which allows them to retain their Medicaid eligibility. In such instances, the person is treated as if he or she is an SSI recipient for Medicaid eligibility purposes. The Medicaid SSI, SSP and protected status coverage groups are described below:
 1. SSI Recipients – There is no distinct State-based eligibility pathway for SSI recipients. Medicaid eligibility is automatic upon approval of SSI. The SSA determines eligibility for SSI and notifies the State of the SSI recipient’s eligibility through an electronic data exchange. The State is responsible for enrollment and the provision of Medicaid health coverage until SSI eligibility ceases unless protected status is available. The EOHHS is responsible for determining whether EAD coverage is available

through an alternative Medicaid eligibility pathway for SSI recipients without protected status who have or are about to lose SSI.

2. State Supplement Payment (SSP) Recipients – Persons who are eligible to receive the optional state-funded supplemental payment are automatically eligible for Medicaid health coverage under the Medicaid State Plan.
 - a. Eligibility criteria. To qualify, a person must be an SSI recipient, a former SSI recipient with Medicaid protected status, or a person who meets the criteria for EAD or LTSS and resides in one (1) of several pre-approved SSP living arrangements as specified in R.I. Gen. Laws § 40-6-27.2.
 - b. Determination process. The SSA determines eligibility for SSP for SSI recipients. As the State agency that shares responsibility with the SSA for administering the SSI program in Rhode Island, the Rhode Island Department of Human Services (DHS) requires non-SSI recipients to qualify for SSP on the basis of the EAD or applicable LTSS eligibility criteria. Eligibility criteria for all other SSP categories are located in the DHS Code of Administrative Rules in the section entitled: Supplemental Security Income (SSI) and State Supplemental Payment Program and are available on the RI Secretary of State's website at: <http://sos.ri.gov/>.
 - c. Continuing eligibility. Renewal of Medicaid for SSP recipients is conducted in accordance with the requirements for SSI or EAD, depending on the basis of eligibility, and the applicable requirements related to living arrangement. The amount of the payment, which depends on a characteristic, living arrangement and certain other factors, is not considered in determining countable income for continuing Medicaid eligibility purposes. Medicaid eligibility based solely on SSP ceases when a recipient no longer qualifies for the payment unless there is another basis for coverage. EOHHS will postpone the processing of annual Medicaid eligibility renewals that fall during the novel Coronavirus Disease (COVID-19) declaration of emergency for sixty (60) days or until the termination of the COVID-19 declaration of emergency, whichever is longer. This includes the suspension of periodic data checks for unemployment, SWICA, TALX and other sources and suspension of quarterly post-eligibility verifications.
 - d. Agency responsibilities. The SSA determines initial eligibility for SSP using the SSI methodology and any additional criteria required by the State. DHS determines eligibility for non-SSI recipients through the State's IES. The EOHHS and DHS share responsibility for certifying that a beneficiary qualifies for SSP cash assistance in

Category D (assisted living) and Category F (community supportive living arrangements) based on living arrangement. A need for a Medicaid LTSS is an eligibility condition for Category F.

- e. Applicant/beneficiary responsibilities. SSP beneficiaries must meet all specified application and general eligibility requirements and provide the evidence required to certify payment based on living arrangement.
3. Pickle Amendment Eligibility Pathway – Since enacted in 1977, § 503 of Public Law 94-566, known as the “Pickle Amendment,” protected Medicaid eligibility for certain persons who receive Social Security or Retirement, Survivor, or Disability Insurance (RSDI) benefits. The Pickle Amendment requires the State to apply certain income disregards using a specific federal formula, which essentially deems the person an SSI recipient for Medicaid eligibility purposes.
- a. Eligibility Criteria. Pickle Amendment coverage is available for a person who meets all other SSI eligibility criteria and:
 - (1) Was simultaneously entitled to receive both Social Security RSDI and SSI in some month after April 1977;
 - (2) Receives income that would qualify him or her for SSI after deducting all RSDI cost-of-living adjustments (COLA) received since the last month in which the person was eligible for both RSDI and SSI; and
 - (3) Is currently ineligible for SSI and eligible for and receiving RSDI.
 - b. Determination process. When determining Pickle eligibility, the current SSI federal benefit rate plus any SSP payment is compared to the person’s other countable income plus the amount of the RSDI benefit at the time SSI/SSP eligibility was lost. The COLA at the time Pickle eligibility is determined is disregarded in this calculation as are any COLAs for years prior up to and including the year SSI payments ceased, as long as the date the increase occurred is after April 1977. The result of this calculation is the “Protected Benefit Amount” (PBA) and is used as the basis for determining continuing Pickle Amendment eligibility. Income of any financially responsible family members is factored into the PBA calculation. All other general eligibility criteria apply. However, a MART determination of disability is not required.
 - c. Continuing eligibility. Persons eligible under the Pickle Amendment are subject to EAD passive renewal requirements. The COLA disregards continue to apply as long as income permits. As the SSI

benefit rises from year to year, it may increase to an amount that exceeds the RSDI and the countable income amount at the time SSI eligibility ceased. At this point, the State discontinues Pickle Amendment eligibility and determines whether eligibility through an alternative pathway is available.

- d. Agency responsibilities. SSA informs the State annually about potential “Pickles” at cost-of-living adjustment (COLA) time. The EOHHS is responsible for applying the COLA disregards when determining EAD eligibility of anyone who may qualify for Medicaid in this group. If found ineligible on this basis, the State also evaluates whether Medicaid is available through any other pathway.
- e. Applicant/beneficiary responsibilities. Potential members of this coverage group must provide any additional information that may be required to determine eligibility and comply with the applicable general requirements for SSI-based eligibility set forth in § 1.9 of this Part.
- f. Table of RSDI Cost-of-Living Adjustments. For a history of automatic cost-of-living adjustments, see:
<https://www.ssa.gov/cola/#:~:text=Beginning%20in%201975%2C%20Social%20Security,value%20from%20Social%20Security%20benefits>

4. Employed Persons with Disabilities, 42 U.S.C. § 1619(a)

Working persons with disabilities who have gross earnings at or above the SSI income standard may qualify for continuing payments, and thus Medicaid health coverage, providing they meet all SSI non-disability requirements. The following must be met for 42 U.S.C. § 1619(a) coverage:

- a. Eligibility Criteria. To qualify, the person receiving SSI based on disability must have gross earnings at or above the SSI income standard and:
 - (1) Maintain disability status while working;
 - (2) Meet all other SSI eligibility criteria;
 - (3) Have been eligible for and received a regular SSI payment based on disability for a previous month within the current SSI eligibility period.
- b. Determination process. As long as the beneficiary meets the criteria for 42 U.S.C. § 1619(a), no income or resource standards apply

e.g., income can be above the EAD limits set forth in § 1.5.2 of this Part.

- c. Continuing Eligibility. Medicaid health care coverage for members of this group is automatic and continues until ended by the SSA for any reason for which it may be granted.
 - d. Agency responsibilities. The SSA determines initial and continuing eligibility and notifies the EOHHS on a monthly basis of beneficiaries who qualify for 42 U.S.C. § 1619(a) coverage. The EOHHS is responsible for determining whether beneficiaries who no longer qualify are eligible through an alternative eligibility pathway.
5. Medicaid While Working, 42 U.S.C. § 1619(b) of the Social Security Act, provides Medicaid to employed persons with disabilities who no longer qualify for 42 U.S.C. § 1619(a), but need coverage to continue working. This pathway preserves Medicaid eligibility when a working person's total countable income, both earned and unearned, including deemed income, is too high for an SSI cash payment. Unlike 42 U.S.C. § 1619(a) coverage, 42 U.S.C. § 1619(b) provides "Medicaid While Working" protection when SSI cash benefits are no longer available. Medicaid health coverage is preserved for both members of a couple under 42 U.S.C. § 1619(b) if each is working, and their total combined income would result in the loss of SSI cash benefits, even if the income of one (1) would not alone trigger non-payment status. However, a non-working spouse has no protection under 42 U.S.C. § 1619(b) and loses Medicaid when the earned income of his or her spouse exceeds the limits for SSI cash benefits. For Community Medicaid health coverage through this pathway, the following apply:
- a. Eligibility Criteria. A person must have received an SSI cash payment based on disability, including under 42 U.S.C. § 1619(a), for at least one (1) month in the most recent SSI benefit period, and
 - (1) Continue to meet the disability criteria for SSI payments except for earnings;
 - (2) Have insufficient earnings to replace the SSI/SSP cash benefit, Medicaid health coverage, and/or personal care or attendant services that would be available if they did not have such earnings; and
 - (3) Need Medicaid health coverage to continue to work or obtain employment.
 - b. Determination process. As long as the beneficiary meets the eligibility criteria for Medicaid While Working, and income remains below the 42 U.S.C. § 1619(b) threshold for Rhode Island, which

changes annually and can be obtained on the Social Security Administration's website, no income or resource standards apply.

- c. Continuing Eligibility. Medicaid coverage for members of this group is automatic and continues until ended by the SSA for any reason for which it may be granted or income exceeds the threshold for Rhode Island.
 - d. Agency responsibilities. The SSA determines initial and continuing eligibility and notifies the EOHHS on a monthly basis of beneficiaries who qualify in this coverage group. The EOHHS is responsible for determining whether beneficiaries who no longer qualify for Medicaid through an alternative eligibility pathway.
6. Protected Surviving Spouses – In the Omnibus Budget Reconciliation Act of 1990, Pub. Law. 101-508 (OBRA '90, 1990 U.S.C.C.A.N. 2374). Congress permanently revised eligibility standards set in § 1634(b) of the Social Security Act to protect access to Medicaid health coverage for divorced and surviving spouses who lose SSI eligibility as a result of RSDI benefits.
- a. Eligibility criteria. To qualify, a person must be between the ages of fifty (50) and sixty-five (65) and meet all other eligibility criteria for SSI except for income and the following:
 - (1) Were it not for RSDI benefits, the person would continue to be eligible for SSI and/or SSP;
 - (2) Received an SSI payment the month before RSDI payments began; and
 - (3) Must not eligible for Medicare Part A (hospital coverage insurance).
 - b. Determination process. For the purposes of Medicaid eligibility, the State must disregard the RSDI benefit and consider a person who meets these criteria a deemed SSI recipient until they become eligible for Medicare Part A.
 - c. Continuing eligibility. Medicaid eligibility in this coverage group ends on the first (1st) day of the month the beneficiary becomes eligible for Medicare Part A.
 - d. Agency responsibilities. The SSA notifies the EOHHS that an SSI recipient losing eligibility may qualify for Medicaid through this pathway. Notification is also provided to the State of the date in which Medicare Part A becomes available. The State then determines whether coverage is available through EAD or another

alternative eligibility pathway. The RSDI disregard, the basis for protected status, is no longer included in the determination of countable income when the person is being evaluated for these other forms of Medicaid health coverage.

7. Adult Dependent Child with Disabilities – 42 U.S.C. § 1634 of the Social Security Act provides protection of Medicaid eligibility status for certain adult children with disabilities who lose SSI due to income from a parent's RSDI benefits or Social Security Disability (SSD) benefits from the adult child's own work record. For the purposes of this coverage, "adult child" includes an adopted child, or, in some cases, a stepchild, grandchild, or step grandchild who is unmarried and is age eighteen (18) or older. When determining EAD eligibility for members of this group, the parent's RSDI or child's SSD benefit is disregarded to preserve continuing Medicaid eligibility.
 - a. Eligibility criteria. To qualify for this eligibility pathway, a person must be:
 - (1) At least eighteen (18) years of age;
 - (2) Living with a disabling impairment that began prior to the age of twenty-two (22);
 - (3) An SSI recipient based on blindness or that disabling impairment; and
 - (4) No longer be qualified for SSI due to income resulting only from either the RSDI benefits associated with the retirement, death or disability of a parent or an SSD benefit paid to an adult child with disabilities.
 - b. Determination process. RSDI or SSD benefits paid to the beneficiary are disregarded when calculating countable income. SSI rules for the treatment of income otherwise apply. Protected eligibility is granted if the RSDI or the SSD benefit is the ONLY source of additional income.
 - c. Continuing eligibility. Protected status as a result of the RSDI or SSD disregard continues to apply as long as the beneficiary meets the disability/blindness criteria, there are no additional sources of increased countable income, and resources remain within the applicable limits.
 - d. Agency responsibilities. SSA notifies the State when a recipient loses SSI on this basis and qualifies for the disregards for eligibility through this pathway. The EOHHS is responsible for determining whether other relevant criteria for continuation of protected status

and application of the disregard is warranted. Beneficiaries who lose protected status must be evaluated for alternate forms of Medicaid eligibility before their coverage is terminated.

8. Divorced or Surviving Spouses with Disabilities – This coverage group consists of surviving and divorced spouses who have been determined disabled and lose SSI and/or SSP due to receipt of the RSDI Disabled Widow Benefits (DWB). For Medicaid purposes, these persons are deemed to be SSI recipients until they are entitled to receive Medicare. The SSA is responsible for informing the State of persons who are eligible for continuing eligibility on this basis.
9. State Supplemental Recipients, 12/73 – This coverage group consists of Medicaid beneficiaries eligible under the Medicaid State Plan on the basis of SSI in December 1973 and their spouses who continue to live with them and are essential to their well-being. Medicaid eligibility of the spouse continues as long as the SSI recipient remains eligible under the 1973 eligibility requirements. The SSA notifies the State of persons who are deemed eligible in this group.
10. Surviving Spouses with Disabilities Affected by Actuarial Changes – The Social Security Amendments of 1983, Pub. Law 98-21, eliminated an actuarial reduction formula applied to the RSDI benefits of surviving spouses with disabilities who became entitled to RSDI benefits before age sixty (60). To offset the loss of Medicaid eligibility that occurred as a result, the Consolidated Omnibus Budget Reconciliation [Act](#) (COBRA) of 1985, Pub. Law. 99-272, restored Medicaid eligibility for any surviving spouses with disabilities who lost coverage and filed an application for Medicaid before July 1, 1988. SSA notifies the State of any SSI recipients who may qualify for Medicaid coverage via this eligibility pathway. Eligibility continues until such time as coverage through another Medicaid eligibility pathway becomes available or the beneficiary's countable income exceeds the total of the SSI benefit rate and the RSDI payment at the time protected status was initially conferred.

1.6 The Medicare Premium Payment Program (MPPP)

1.6.1 Scope and Purpose

- A. The Medicare Premium Payment Program (MPPP) helps low-income elders sixty-five (65) and older and adults with disabilities pay all or some of the costs of Medicare Part A and Part B premiums, deductibles and co-payments.
 1. Basis of Eligibility – A person's income and resources, as calculated using the SSI methodology, determine which type of Medicare premium assistance is available. Members of this coverage group are known as

“dual eligible,” as they qualify for both Medicare and Medicaid, as defined below:

- a. Dual eligible beneficiaries who qualify for the MPPP, but not full Medicaid health coverage are referred to as “partial dual eligible” beneficiaries;
 - b. Dual eligible beneficiaries who meet the all the eligibility requirements for an IHCC or MACC group and are enrolled in Medicare Parts A and B are known as “full dual eligible beneficiaries.”
 - c. Dual eligible beneficiaries who receive Medicaid health coverage through the MN pathway, and meet the income requirements for the MPPP, are referred to as “partial dual eligible plus beneficiaries.”
2. Medicare Coverage and the MPPP – Medicare provides the following types of coverage:
- a. Part A. Pays for hospital services and limited skilled nursing services. Medicare Part A is provided at no-cost to a person who: is insured under Social Security or Railroad Retirement Systems (e.g., paid into the system for forty (40) quarters of work) and sixty-five (65) years of age; has reached the twenty-fifth (25th) month of a permanent and total disability; or received continuing kidney dialysis or had a kidney transplant. Under an agreement with the SSA, the State is authorized to purchase Part A through the MPPP for persons who are elderly or living with a disability who do not qualify for no-cost Part A coverage.
 - b. Medicare Part B. Pays for physician services, durable medical equipment and other outpatient services. Medicare Part B is available to persons who pay a monthly premium and are sixty-five (65) years of age or older without regard to whether they are insured in the Social Security or Railroad Retirement Systems as well anyone who has reached the twenty-fifth (25th) month of a permanent and total disability. Initial enrollment is a seven (7) month period that starts three (3) months before a person first qualifies for Medicare and extends three months past the sixty-fifth (65th) birthday or, if failing to enroll during this period, through an open enrollment period held each year from January through the end of March. The State pays the Part B premium for Medicare beneficiaries eligible through all of the MPPP eligibility pathways listed below.

- c. Medicare Part C. Medicare managed care (“Advantage” plans) provide Medicare Part A, Part B and Part D (prescription drug coverage) for beneficiaries who qualify.
- d. Medicare Part D. Pays for prescription drug coverage for enrolled Medicare beneficiaries. Costs for beneficiaries vary. Low-income Medicare beneficiaries who qualify for the federal government’s Extra Help program, which provides assistance in paying the costs for Part D, are automatically eligible for the MPPP. The SSA provides electronic notification to the states of Medicare beneficiaries who are eligible for the MPPP on this basis.
- e. Medicaid wraps around Medicare’s coverage by providing financial assistance to beneficiaries in the form of payment of Medicare premiums and cost-sharing, as well as coverage of some benefits not included in the Medicare program. Not all dual eligible beneficiaries receive the same level of Medicaid benefits, as indicated below.

1.6.2 MPPP Eligibility Pathways

- A. The specific eligibility requirements and benefits coverage groups included in the MPPP pathway are as follows:
 - 1. Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only) – Financial assistance in this group is provided to beneficiaries who are eligible for or enrolled in Medicare Part A, have countable income of one hundred percent (100%) of FPL or less and resources that do not exceed the amounts set annually by the federal government (see § 1.6 of this Part). For partial dual eligible QMBs:
 - a. Medicaid makes a direct payment to the federal government for the Part A premium (if any), the Part B premium, and provides payments for Medicare co-insurance and deductibles as long as the total amount paid by Medicare does not exceed the amount Medicaid allows for the service.
 - b. Eligibility begins on the first (1st) day of the month after the application is filed and all eligibility requirements are met.
 - c. Eligibility is renewable in twelve (12) month periods.
 - d. Deeming rules do not apply.
 - e. There is no retroactive coverage.
 - 2. QMBs with Medicaid health coverage (QMB Plus) – Persons who qualify through this pathway must be entitled to Medicare Part A, have countable

income at or below one hundred percent (100%) of the FPL, and resources at four thousand dollars (\$4,000) an individual or six thousand dollars (\$6,000) a couple. Beneficiaries eligible through this pathway are full dual eligible beneficiaries and receive premium assistance and Medicaid health coverage. Includes MN Medicaid beneficiaries. Access to Medicaid retroactive coverage, continuing eligibility, and the full scope of Medicaid essential benefits is available.

3. Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only) – These individuals are entitled to Medicare Part A, have countable income of greater than one hundred percent (100%) FPL, but less than one hundred twenty percent (120%) FPL, resources within the federally defined limits, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.
 - a. Medicaid pays the Medicare Part B premium to SSA
 - b. Eligibility begins on the first (1st) day of the month in which the application is filed and all eligibility requirements are met.
 - c. Eligibility is authorized for a twelve (12) month period and is renewable on that basis.
 - d. Deeming rules do not apply.
 - e. Retroactive coverage may be available.
4. SLMBs with Medicaid health coverage (SLMB Plus) – To be eligible through this pathway, a person must be entitled to Medicare Part A, have countable income of greater than one hundred percent (100%) FPL but less than one hundred twenty percent (120%) FPL, and resources of no more than four thousand dollars (\$4,000) for an individual or six thousand dollars (\$6,000) a couple. A person qualifies for Medicaid through this pathway only if MN requirements are met. In addition to full Medicaid essential benefits, the MPPP also pays the beneficiary's Medicare Part B premiums, coinsurance, deductibles and copayments.
5. Medicaid pays the SSA. Community Medicaid EAD general eligibility requirements govern access to Medicaid retroactive coverage, continuing eligibility, and scope of coverage.
6. Qualified Disabled and Working Individuals (QDWIs) – This pathway covers beneficiaries who lost their Medicare Part A benefits due to their return to work. They must be eligible to purchase Medicare Part A benefits, have countable income of two hundred percent (200%) FPL or less and resources that do not exceed twice the limit for SSI eligibility (EAD limits of four thousand dollars (\$4,000) for an individual or six

thousand dollars (\$6,000) for a couple), and must not be otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

- a. Medicaid makes a direct payment to the SSA for the Part A premium;
 - b. Eligibility begins the month in which all requirements are met, including enrollment in Part A, and continues for a year unless or until changes in employment result in resumption of Medicare without MPPP assistance.
7. Qualifying Individuals-1 (QI-1) – To qualify for eligibility through this pathway, beneficiaries must be entitled to Medicare Part A, have countable income of at least one hundred twenty percent (120%) FPL, but less than one hundred thirty-five (135%) FPL, resources that do not exceed the amounts set by the federal government (see § 1.6 of this Part), and be otherwise ineligible for Medicaid. Medicaid pays Medicare Part B premiums only. Federal matching funds for members of this group is one hundred percent (100%) and, as such, the availability of financial assistance through QI-1 eligibility is contingent on federal appropriations. For members of this group:
- a. Medicaid makes a direct payment to the SSA for the Part B premium.
 - b. Eligibility begins the month in which the application is filed and all requirements are met and ends on December thirty-first (31st) of the year in which the application is filed.
 - c. Cost-of-living increases in Title II benefits (COLAs), effective in January each year, are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty Guideline update is published.
 - d. Deeming applies.
 - e. Retroactive coverage is available.
8. MN and QMB (+) and SLMB (+) – Participation in the MPPP may adversely affect the income eligibility of a person seeking initial or continuing Medicaid health coverage through the MN pathway. As the State pays some or all Medicare costs for MPPP participants, these allowable health expenses cannot be counted toward a MN spenddown. This, in turn, may make it difficult to obtain Medicaid health coverage for high costs services that are covered only in part or not at all by Medicare. MPPP enrollment may also affect other forms of Medicaid eligibility if it changes the way income or resources are counted. An agency eligibility specialist should be consulted by an applicant or beneficiary who is

concerned that enrolling in the MPPP will affect access to Medicaid health coverage.

1.6.3 MPPP Application Process

- A. There are multiple application pathways for pursuing MPPP eligibility.
1. MPPP – Persons seeking MPPP coverage may apply through the State or the SSA. If applying through the State’s IES, a person has the option of applying for the MPPP only or Medicaid health coverage and the MPPP.
 2. LIS and Social Security Administration (SSA) – An application for the LIS program is available online at: <https://secure.ssa.gov/i1020/start> or by calling 1-800-772-1213 or TTY 1-800-325-0778, Monday-Friday 7am-7pm. The State uses information provided by the SSA for determining LIS eligibility to initiate an application for the MPPP, when appropriate.

1.6.4 MPPP Eligibility and Continuing Eligibility

Persons seeking MPPP assistance are subject to the SSI-methodology for determining financial eligibility, though the income and resources standards specific to the MPPP coverage group, as indicated in § 1.6 of this Part, are applied. A disability determination is not required for MPPP financial help only. With the implementation of the State’s IES, continuing eligibility is determined using a modified passive renewal process (See [§ 00-2.7.2\(A\)\(5\)](#) of this Chapter).

1.6.5 MPPP Summary

- A. The following provides a summary of the MPPP eligibility pathways by coverage group that shows current year financial eligibility limits and the benefits provided:

MPPP Eligibility Pathways			
Coverage Group	Full or Partial Eligible	Income and Resource Limits Individual/Couple	Benefits
QMB	Partial Dual	100% FPL All MPPP applicants receive a \$20 income disregard. \$7,560 – Individual \$11,340 – Couple	Entitled to Medicare Part A and qualify for Medicaid payment of: Medicare Part A premiums (if needed) Medicare Part B premiums Certain premiums charged by Medicare Advantage plans Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program)
QMB +	Full Dual	100% FPL \$4,000/\$6,000	All of the above AND Medicaid health coverage
SLMB	Partial Dual	101-125% FPL \$ \$7,560 – Individual \$11,340 – Couple	Entitled to Medicare Part A and qualify for Medicaid payment of: Medicare Part B premiums

MPPP Eligibility Pathways			
Coverage Group	Full or Partial Eligible	Income and Resource Limits Individual/Couple	Benefits
SLMB +	Full Dual	101-120% FPL \$4,000/\$6,000	Same as above AND: Certain premiums charged by Medicare Advantage plans Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program) Full Medicaid Coverage
QI	Partial Dual	121-135% FPL \$7,560 – Individual \$11,340 – Couple	Entitled to Medicare Part A and qualify for Medicaid payment of: Medicare Part B premiums
QWDI	Partial Dual	\$4,000 – Individual \$6,000 – Couple	Lost Medicare Part A benefits because of return to work but eligible to purchase Medicare Part A and qualify for Medicaid payment of: Medicare Part A premiums

1.7 Special Coverage Groups

1.7.1 Overview

There are certain IHCC groups that are exempt from various income and/or resource requirements because they provide coverage to people with unique characteristics and/or health needs.

1.7.2 Breast and Cervical Cancer

- A. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Pub. Law. 106-354), amended Title XIX to include an optional Medicaid coverage group for uninsured women who are screened and need treatment for breast or cervical cancer or for precancerous conditions of the breast or cervix. The Rhode Island Department of Health (DOH), Women's Cancer Screening Program, is responsible for administering the screening required for Medicaid eligibility through this pathway.
1. Eligibility Criteria – To qualify, an applicant must be under age sixty-five (65) and receive screening for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program administered by DOH and found to need treatment for either breast or cervical cancer, or a precancerous condition of the breast or cervix. In addition, an applicant must not be Medicaid eligible in another coverage group or have access to or be enrolled in a health insurance plan that provides essential benefits, as defined in federal regulations at 42 C.F.R. § 447.56. All general requirements for Medicaid must also be met. There is no resource limit. Retroactive eligibility is available for eligible members of this coverage group and no disability determination is required.
 2. Determination process – Members of this coverage group are not required to meet EAD income and resource limits or those established for other Medicaid eligibility pathways. Under the State's § 1115 waiver, income eligibility for members of this coverage group is set at two hundred fifty percent (250%) of the FPL. In addition, presumptive eligibility is also available to women who meet the screening requirements, prior to a full determination of Medicaid eligibility, if the woman is a resident of the State.
 3. Continuing eligibility – A redetermination of Medicaid eligibility must be made periodically to determine whether the beneficiary continues to meet all eligibility requirements. Eligibility ends when the beneficiary:
 - a. Attains age sixty-five (65);
 - b. Acquires qualified health insurance/creditable coverage;
 - c. No longer requires treatment for breast or cervical cancer;

- d. Fails to complete a scheduled redetermination;
 - e. Is no longer a Rhode Island resident; OR
 - f. Otherwise does not meet the eligibility requirements for the program.
4. Agency responsibilities – The DOH administers the screening and application segments of the program. EOHHS conducts redeterminations and renewals and is responsible for providing timely notice and the right to appeal when any change in eligibility occurs.
 5. Applicant/beneficiary responsibilities – Beneficiaries are responsible for providing timely and accurate information about the status of their condition/treatment prior to the date of redetermination or at intervals specified.

1.7.3 Refugee Medical Assistance (RMA) – MN Option

- A. Refugee Medical Assistance (RMA) is a one hundred percent (100%) federally funded program for individuals and families operating under the auspices of the U.S. Department of Health and Human Services, Office of Refugee Resettlement (ORR). RMA is an eligibility pathway for individuals and families who are otherwise ineligible for Medicaid. Until enactment of the ACA, all persons seeking RMA were evaluated using the SSI methodology, through the MN eligibility pathway. The ORR has waived these requirements and directed that, prior to a determination for RMA, states should evaluate all participants in its programs for Medicaid and commercial coverage, using the MAGI methodology (MACC groups under the Medicaid Code of Administrative Rules, Overview of Affordable Care Coverage Groups and HSRI) and SSI-related coverage (§ 1.5 of this Part) before pursuing RMA through the MN pathway.
 1. Eligibility Criteria – Any member of the federal resettlement program for refugees who has income at or below two hundred percent (200%) of the FPL and is otherwise ineligible for Medicaid or an HSRI plan providing financial help, may apply for RMA using the MN process. This included adults nineteen (19) to sixty-four (64) who have no other Medicaid MN eligibility option and certain persons in need of LTSS. The criteria set forth in § 1.11.6 of this Part for Community Medicaid apply for establishing the spenddown period and allowable expenses except there are no resource requirements and deeming is not permitted.
 2. Determination Process – All persons seeking Medicaid coverage who have refugee status are evaluated for MACC group eligibility first using the MAGI before being evaluated for IHCC group coverage using the SSI methodology or special eligibility requirements in this section. This includes the MN pathways identified in Community Medicaid: Medically Needy Eligibility, Part [2](#) of this Subchapter for elders, adults with

disabilities, children, parents/caretakers, and pregnant women. If determined ineligible through these pathways, the person is evaluated for coverage through HSRI and then MN eligibility pathway through RMA. The RMA MN eligibility pathway requires a beneficiary to spenddown to the MNIL for elders and adults with disabilities, adjusted for family size.

3. Continuing Eligibility – Receipt of RMA under the characteristic of "refugee" is limited to the first eight (8) months residing in the United States, beginning with the month the refugee initially entered the United States, or the entrant was issued documentation of eligible status by the federal government.
 - a. Coverage Limit. Coverage and one hundred percent (100%) federal matching funds continue until the end of the eighth (8th) month or the date in which the person no longer meets the immigration status requirement, whichever comes first. Prior to ending eligibility for Medicaid through this pathway, a review of other possible forms of Medicaid eligibility is conducted by the State.
 - b. No Five Year Bar. Federal law exempts refugees from the five (5) year bar for qualified non-citizens established under the U.S. Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, 42 U.S.C 1305 § 401. Once the (8) eight month RMA period ends, states are required to continue Medicaid eligibility under any other coverage group for which a refugee may qualify providing all other requirements are met. (See Medicaid Code of Administrative Rules, Evaluation of Resources, for more immigration information.) Renewals for continuing coverage are conducted in accordance with the applicable coverage group requirements including six (6) month budget periods through the MN pathway.
4. Agency responsibilities – Beneficiaries eligible under this section are required to meet the spenddown requirements set forth in Part [2](#) of this Subchapter. The agency is responsible for ensuring that the spenddown period coincides with the eligibility period. In addition, the EOHHS must evaluate each applicant/beneficiary in this group for MAGI-based Medicaid and HSRI eligibility prior to granting MN eligibility. Federal payment for eight (8) months is provided regardless of pathway.
5. Applicant/beneficiary responsibilities – Beneficiaries are responsible for meeting the spenddown requirements set forth in Part [2](#) of this Subchapter.

1.7.4 Sherlock Plan

The Sherlock Plan Medicaid for Working People with Disabilities Program is an SSI-related IHCC group comprised of working adults with disabilities pursuant to the Balanced Budget Act of 1997, 42 U.S.C. § 1396a(a)(10)(ii)(XIII). Eligibility for the Sherlock Plan is included in Medicaid Code of Administrative Rules, Sherlock Program, which focuses on Medicaid eligibility for adults with disabilities who are working.

1.7.5 Emergency Medicaid

- A. Medicaid health coverage is available to non-citizens in emergency situations without regard to immigration status.
1. Eligibility Criteria – To qualify for emergency Medicaid, a non-citizen must meet all of the eligibility requirements for a MACC or an IHCC group, except for immigration status. Persons seeking emergency Medicaid are evaluated as follows:
 - a. Persons under age sixty-five (65). All persons in this group are evaluated for the MACC groups identified in Medicaid Code of Administrative Rules, Overview of Affordable Care Coverage Groups, using the MAGI, at the income limit applicable for the population to which they belong – e.g., child, adult or parent/caretaker, pregnant woman. There is no resource limit and no determination of disability.
 - b. Elder sixty-five (65) and older. Non-citizens in this category are evaluated using the IHCC Community Medicaid EAD eligibility requirements and income standard. Resource limits apply, but there is no determination of disability.
 - c. Medically Needy. Persons who are ineligible under §§ 1.7.5(1)(a) or (b) of this Part because their income is too high, may seek coverage through the IHCC pathway as MN in accordance with § 1.5.3 of this Part and Part [2](#) of this Subchapter in detail.
 - d. In addition, the person must require treatment for an emergency health condition in accordance with the prudent layperson standard – as defined in the Federal Balanced Budget Act of 1997, Pub. Law. 105-33 – as specified below and obtain such services from a certified Medicaid provider. Such an emergency health condition is:
 - (1) A health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. [During the novel Coronavirus Disease \(COVID-19\) declaration of emergency, a diagnosis of, and treatment for, COVID-19 is to be considered an emergency health condition.](#)

2. Determination Process – Emergency service providers – typically an acute care facility such as a hospital – provide assistance with completing any required forms upon determining, in conjunction with the presumptive eligibility process specified in Medicaid Code of Administrative Rules, Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals, that emergency Medicaid coverage may be required. In situations in which eligibility for emergency Medicaid cannot be determined or ascertained in this process, an agency eligibility specialist is contacted to provide the non-citizen with assistance in applying for coverage and assuring payment is made for any of the Medicaid-covered emergency services rendered. MN eligibility is available, as a last resort, for non-citizens who have income above the applicable eligibility limits for other coverage groups if the costs incurred for emergency services are sufficient for a spenddown. Payments to providers are typically made post-treatment.
3. Continuing Eligibility – Emergency Medicaid coverage is limited to the period in which the emergency health condition is treated. Under applicable federal regulations, such coverage does not include any follow-up services deemed medically necessary to prevent the need in the future for emergency services for the same illness, disease or condition in an acute care facility.
4. Agency responsibilities – The EOHHS is responsible for assisting in the application process and making timely payment for services provided under this subsection, including for any services billed separately by licensed providers and professionals as long as the costs were incurred during the emergency health period for the condition specified.
5. Applicant/beneficiary responsibilities – Applicants must provide timely and accurate information on all eligibility factors unrelated to immigration status required for making a determination for Medicaid health coverage.

1.8 Community Medicaid – LTSS Preventive Services

1.8.1 Authority

Under the terms of the State’s § 1115 demonstration waiver, Community Medicaid beneficiaries who do not yet need Medicaid LTSS but are at risk for the nursing facility institutional level of care have access to LTSS preventive services. Beneficiaries who meet the needs-based criteria for these LTSS

preventive services are eligible for a limited range of home and community-based services and supports along with the full range of primary care essential benefits they are entitled to receive. The goal of preventive services is to delay or avert LTSS institutionalization or more extensive and intensive home and community-based care.

1.8.2 Scope of Services

- A. Depending on a beneficiary's needs, the following LTSS preventive services may be available to Community Medicaid beneficiaries:
1. Limited Certified Nursing Assistant/Homemaker Services – These services include general household tasks (e.g., meal preparation and routine household care) and are available when a beneficiary can no longer perform them on their own and there is no other person available to provide assistance. Limited personal care may also be available.
 - a. Maximum hours available: six (6) hours per week for a single beneficiary or ten (10) hours per week for a household with two (2) or more beneficiaries.
 2. Minor Environmental Modifications – Minor modifications may be available to a beneficiary to facilitate independence and the ability to live at home or in the community safely. Such modifications may include: grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, simple devices, such as: eating utensils, a transfer bath bench, shower chair, aids for personal care (e.g. reachers) and standing poles.

1.8.3 ~~Clinical Review~~ Prior Authorization

To qualify, ~~the Office of Medicaid Review (OMR) must determine the~~ beneficiary's Health Care provider must provide documentation that that one (1) or more LTSS preventive services will improve or maintain the ability of a beneficiary to perform Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) and/or delay or mitigate the need for intensive home and community-based or institutionally based care. Detailed information about the clinical standards and review process is provided in the Medicaid Code of Administrative Rules, Global Consumer Choice Waiver.

1.8.4 Limits

To qualify for preventive level services, there must be no other form of coverage for the services provided and no other person or agency responsible or capable for doing so.

1.8.5 Continuing Need

The need for LTSS preventive services is reassessed annually in conjunction with the renewal process. Preventive services continue until the beneficiary reports that the risk for LTSS has been mitigated or a follow-up [functional assessment](#) ~~clinical evaluation~~ conducted by the [State or State designee OMR](#) finds that such services need to be changed or terminated. ~~Beneficiaries are notified of the date of a clinical review at least ninety (90) days in advance.~~

1.9 Community Medicaid General Eligibility Requirements

1.9.1 Scope and Purpose

All applicants for Medicaid in the IHCC groups must meet general eligibility requirements in addition to those related to income, resources, and clinical need.

1.9.2 Characteristic Requirements

- A. Unless specifically exempt, a person applying for Community Medicaid when eligibility is determined by the state must establish their categorical relationship to SSI by qualifying on the basis of one (1) of the following characteristics:
1. Age – A person qualifying on the basis of age must be at least sixty-five (65) years of age in or before the month in which eligibility begins.
 - a. Verification: An applicant's age is verified electronically with information about date of birth from the SSA and/or the Rhode Island Department of Health, Division of Vital Statistics. If data matches are unsuccessful, an applicant is required to provide paper documentation of date of birth to support a self-attestation of age.
 2. Disability – Determined to meet the SSI disability criteria applied by the MART, or the SSA for SSI cash benefits or RSDI or SSD. Note: An applicant must be determined disabled due to blindness by the MART or by an entity of the SSA. If income is at or below SSI income standard, a disability determination for blindness is NOT required.

1.9.3 Non-Financial Criteria

- A. Applicants must also meet all of the following non-financial eligibility criteria for Medicaid:
1. Social Security Number – Each person applying for Medicaid must have a Social Security Number (SSN) as a condition of eligibility for the program.
 - a. Condition of Eligibility. Applicants must be notified prior to or while completing the application that furnishing an SSN is a condition of eligibility. Only members of a household who are applying for Medicaid are required to provide an SSN, however. An SSN of a non-applicant may be requested to verify income. Refusal of a non-

applicant to provide an SSN cannot be used as a basis for denying eligibility to an applicant who has provided an SSN. If an SSN is unavailable, other proof of income must be accepted.

- b. Limits on Use. Applicants must also be informed that their SSN will be utilized only in the administration of the Medicaid program, including in verifying income and eligibility.
 - c. Verification. SSN is verified through an electronic data-match with the SSA. Applicants must provide documentation of SSN if the data match fails. Paper documentation indicating that an application for an SSN has been made is required for applicants who do not have an SSN at the time of application.
2. Residency – A person must be a resident of Rhode Island to be eligible for Medicaid. The state of residence of a person is determined according to the following:
- a. SSP. For persons receiving an SSP payment, the state of residence is the state paying the supplement. Exception: Persons involved in work of a transient nature or who have moved to the state to seek employment may claim Rhode Island as their state of residence and be granted Medicaid in Rhode Island if they meet all other eligibility criteria. These persons may be granted Rhode Island Medicaid even though they continue to receive a state supplemental payment from another state.
 - b. Persons under twenty-one (21). Residency is determined as follows for minors:
 - (1) A person who is blind or living with a disabling impairment under the age of twenty-one (21) who is not residing in an institution, the state of residence is the state in which the person is living.
 - (2) Any person residing in a health care or treatment facility who is under the age of twenty-one (21), or who is twenty-one (21) or older and became incapable of indicating intent prior to the age of twenty-one (21), the state of residence is that of:
 - (AA) The parents or legal guardian, if one (1) has been appointed, or
 - (BB) The parent applying for Medicaid on behalf of the person if the parents live in different states, or

- (CC) The person or party who has filed the application on behalf of the applicant if the applicant has been abandoned by his or her parents and does not have a legal guardian.
- c. Persons twenty-one (21) and older. For adults age twenty-one (21) or older, residence is determined as follows:
 - (1) If not living in an institution, the state of residence is the one in which the person is living:
 - (AA) With intent to remain permanently or for an indefinite period of time;
 - (BB) While incapable of stating intent; or
 - (CC) After entering with a job commitment or in pursuit of employment whether or not currently employed.
 - (2) A person age twenty-one (21) or older who is residing in a health institution and became incapable of stating intent at or after age twenty-one (21), residing is in the state in which the person is physically present, unless another state arranged for placement in a Rhode Island institution.
 - (3) For any other person age twenty-one (21) or older living in an institutional setting, residence is in the state where the person is living with the intention to remain permanently or for an indefinite period, unless another state has made a placement. A person living in a health care institution cannot be considered a Rhode Island resident if he or she owns a home in another state and has an intent to return there even if the likelihood of return is apparently nil.
- d. **Absence Due to Military Assignment.** A blind or impaired child who travels out of the State for an indefinite period with a parent in the armed forces is no longer eligible for Medicaid or SSP even if SSI benefits continue.
- e. **Temporary Absence.** Temporary absences from Rhode Island for any of the following purposes do not interrupt or end Rhode Island residence:
 - (1) Obtaining necessary health care;
 - (2) Visiting;

- (3) Obtaining education or training under a program of the Rhode Island Office of Rehabilitation Services (ORS), Work Incentive or higher education program, or
 - (4) Residing in an LTSS facility in another state, if arranged by an agent of the State of Rhode Island, unless the person or his/her parents or guardian, as applicable, stated an intent to abandon Rhode Island residence and to reside outside Rhode Island upon discharge from LTSS.
- f. Placement in Rhode Island Institutions. When an agent of another state arranges for a person's placement in a Rhode Island institution, the person remains a resident of the state which made the placement, irrespective of the person's intent.
 - g. Incapable of Stating Intent. Persons are incapable of stating intent regarding residence if they are judged to be legally incapable of doing so or there is medical documentation or other documentation acceptable for such purposes that supports a finding that they are incapable of stating intent.
 - h. Residence as Payment Requirement. A person must be a resident of Rhode Island at the time a medical service is rendered in order for Rhode Island Medicaid to pay for that service. The service does not, however, have to be rendered in Rhode Island.
 - i. Specific Prohibitions. Under federal law, the State may not deny Medicaid eligibility to an applicant for any of the following reasons:
 - (1) Failure to reside in the State for a specified period; or
 - (2) Failure of a person receiving care in an institutional setting to establish residence in the State before entering the institution if otherwise satisfying the residency rules set forth in this section; or
 - (3) Temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another state has determined that the person is a resident there for purposes of Medicaid; or
 - (4) Failure to have a permanent or fixed address. Homeless persons may designate a mailing address.
 - j. Verification – At the time of initial application for Medicaid, self-attestation of Rhode Island residency is accepted and/or verified electronically and the intent to remain is accepted unless required

for the evaluation of resources or income that has been earned by the applicant in another state.

3. Living Arrangements – A person’s living arrangement is a factor when determining eligibility for programs and payment amounts that may directly or indirectly affect access to Medicaid for certain Medicaid services. In addition, incarceration is also a factor that affects eligibility status and access to Medicaid coverage.
 - a. Financial eligibility. The financial responsibility of relatives varies depending upon the type of living arrangement. Thus, when determining financial eligibility, the living arrangements of individuals and couples matter as follows:
 - (1) Living in own home such as a house, apartment, or mobile home or someone else’s household. Affects Medicaid MACC household composition and RItE Share participation and thus is a factor considered in the process noted in § 1.9.3(2) of this Part.
 - (2) Residing in a community-based group care or board and care facility such as assisted living, supportive home for persons with developmental disabilities or behavioral health needs. Determines Medicaid eligibility group size and cap on room and board charges and allowances and contributions to cost of care;
 - (3) Residing in a health care or treatment institution such as a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities, residential care facility for adults or children requiring treatment or rehabilitation services. An institution is, for these purposes, an establishment that furnishes food, shelter and some health treatment, services, and/or supports to four (4) or more persons unrelated to the proprietor. Determines Medicaid eligibility group size and countable income;
 - (4) Persons who are homeless are considered to be living in their own homes if they reside in a shelter or move from one temporary living arrangement to another for more than six (6) months during a calendar year.
 - b. SSP. Eligibility for and the amount of the optional state supplemental payment is affected by the following living arrangements which, in turn, may determine a Medicaid beneficiary’s choice of care settings:

- (1) Residence in a hospital or nursing facility for the whole month and Medicaid pays for over one-half (1/2) of the cost of care;
 - (2) Medicaid LTSS beneficiary living in either an appropriately certified residence/home participating in the Medicaid Community Supportive Living Program established under R.I. Gen. Laws § 40-8.13-12, or Medicaid certified assisted living residence authorized in accordance with R.I. Gen. Laws § 40-6-27;
 - (3) Medicaid beneficiary who is SSI or EAD eligible (non-LTSS) and is residing in an assisted living residence;
 - (4) Medicaid beneficiary under twenty-one (21) residing in a hospital or nursing facility for the entire month and private insurance and/or Medicaid together pay over one half (1/2) of the cost of care; or
 - (5) Medicaid beneficiary of an age or IHCC group residing in a public or private health care treatment facility and Medicaid is paying for more than one half (1/2) of the cost of care. If residing in the facility for the whole month, the SSP payment is limited to fifty dollars (\$50).
- c. Verification – For both Medicaid eligibility (a) and SSP (b), self-attestation of living arrangement is accepted during initial application for persons living in their own homes or in someone else's household. Documentation certifying that a person is or will be residing in a community-based residence that qualifies for one (1) of the special SSP payments is required. Proof of living in a health care or treatment institution must be provided when no other source of verification is available. Notification to EOHHS and DHS of change in living arrangement from a community-based to an institutional setting or the reverse is mandatory and must be made within ten (10) days of the date the change occurs for all applicants and beneficiaries.
- d. Correctional Facility. While living in a correctional facility, including a juvenile facility, Medicaid health coverage for otherwise IHCC eligible persons is suspended except for in-patient and emergency services provided outside of the facility. Residence in a correctional facility begins on the date of incarceration and continues until the date the person is released from the correctional facility. A person transferred from a correctional facility to a hospital for part or all of the sentencing period is considered to be still living in the correctional facility for general eligibility purposes, unless the

exemption for Medicaid coverage of in-patient and emergency care applies.

- e. Verification. Self-attestation of incarceration is accepted initially and then verified through information exchanges with the Rhode Island Department of Corrections (DOC). In addition, electronic data matches with DOC records are conducted on a regular basis in conjunction with the post-eligibility verification process.

4. Citizenship and Immigration Status – Immigration and citizenship status affect Community Medicaid eligibility as follows:

- a. Citizen or Qualified Non-citizen. An applicant for coverage in one (1) of the IHCC groups must be a United States citizen or a lawfully present “qualified” non-citizen immigrant who has been in the U.S. for five (5) years or more. Lawfully present qualified non-citizens include persons in the U.S. as legal permanent residents (LPR), with humanitarian statuses or as a result of such circumstances (e.g., refugees, asylum applicants, temporary protected status), valid non-immigrant visas, and legal status conferred by other federal laws (temporary resident, LIFE Act, Pub. Law. 106-553 and 554, Family Unity Act, 8 C.F.R. Part 236(B) etc.). There are exceptions in federal law and, more generally, under the Rhode Island Medicaid Program which permit qualified non-citizens who might otherwise be subject to the bar to obtain Medicaid health coverage. These exceptions are located in the Medicaid Code of Administrative Rules, Evaluation of Resources. General exceptions specific to Rhode Island are as follows:

- (1) Pregnant women are eligible if they meet all other requirements regardless of immigration status.
- (2) Lawfully present children who meet all other requirements are eligible during the five (5) year bar under the State’s Children’s Health Insurance Program (CHIP) State Plan. Eligibility under CHIP also extends to lawfully present children in the U.S. on non-immigrant visas who are treated as qualified non-citizens exempt from the five (5) year bar.

- b. Non-qualified Non-citizen. With the exception of pregnant women, adult “non-qualified” non-citizens are not eligible for Medicaid. Non-qualified non-citizens are persons from other nations who are not considered to be immigrants under current federal law, including those in the United States on a time-limited visa (such as visitors or persons s in the U.S. on official business) and those who are present in the country without proper documentation (includes people with no or expired status). Non-qualified non-citizens may obtain

Medicaid health coverage in emergency situations only, as indicated in § 1.7.5 of this Part. Non-emergency services may be obtained through Federally Qualified Community Health Centers.

- (1) Lawfully present adult non-citizens may be eligible for commercial coverage, with financial assistance, through HSRI. Further information is available at:
www.healthsourceri.org.
 - c. Verification: **Individuals** who are applying for coverage must provide their immigration and citizenship status. Non-applicants in the FRU are exempt from the requirement. Any information provided by an applicant on paper or electronically must be used only for verifying status. Acceptable documentation, when required, is set forth in the Medicaid Code of Administrative Rules, Technical Eligibility Requirements as well as Eligibility Requirements.
5. Other Forms of Cooperation – Rhode Island’s Medicaid State Plan states that as a condition of eligibility for Medicaid, applicants must at the time of application:
- a. Agree to cooperate in identifying and providing information to assist the State in pursuing any third (3rd) party who may be liable to pay for care and services;
 - b. Agree to cooperate with the State in obtaining medical support and payments (e.g., signing papers necessary to pursue payments from absent parents);
 - c. Agree to apply for eligibility for any other forms of public assistance which may be available upon receiving notification from the EOHHS in accordance with the Medicaid Code of Administrative Rules, Resources Generally;
 - d. Enroll in a RIte Share-approved employer-sponsored health insurance plan if cost-effective to do so, in accordance with the Medicaid Code of Administrative Rules, RIte Share Program; and
 - e. Agree to cooperate in establishing the paternity of a child born out of wedlock for whom the applicant can legally assign rights.

1.9.4 Good Cause for Failing to Cooperate

- A. A Medicaid applicant or beneficiary must have the opportunity to claim good cause for refusing to cooperate. Good cause may be claimed by contacting an agency representative. To claim good cause, a person must state the basis of the claim in writing and present corroborative evidence within twenty (20) days of the claim; provide sufficient information to enable the investigation of the

existence of the circumstance that is alleged as the cause for non-cooperation; or, provide sworn statements from other persons supporting the claim.

1. A determination of good cause is based on the evidence establishing or supporting the claim and/or an investigation by EOHHS agency staff of the circumstances used as justification for the claim of good cause for non-cooperation.
 2. The determination as to whether good cause exists must be made within thirty (30) days of the date the claim was made unless the agency needs additional time because the information required to verify the claim cannot be obtained within the time standard. The person making the claim must be notified accordingly.
- B. Upon making a final determination, notice must be sent to person making the claim. The notice must include the right to appeal through the EOHHS Administrative Fair Hearing Process set forth in the Medicaid Code of Administrative Rules, Complaints and Appeals, or its successor regulation.

1.10 State-Administered Community Medicaid Disability Determinations

1.10.1 Scope and Purpose

Disability determinations are made by the State's Medicaid Assessment and Review Team (MART) in accordance with the applicable requirements of the SSA based on information supplied by the applicant and by reports obtained from treating physicians and other health care professionals. Anyone who is blind and is seeking IHCC group Community Medicaid who does not qualify for SSI or has never received a determination of disability on that basis by a government agency, is subject to an evaluation by the MART.

1.10.2 Disability Standards for Community Medicaid

- A. For the purposes of IHCC groups providing Community Medicaid, the standards for determining whether a person has a disability centers on:
1. Duration – The disabling impairment or chronic condition is expected to result in death or has lasted or can be expected to last for at least twelve (12) consecutive months;
 2. Substantial Gainful Activity – The impairment or condition adversely affects the person's ability to engage in substantial gainful activity or SGA. For these purposes, SGA is work activity that involves doing significant physical or mental activities. Work may be substantial even if it is done on a part-time basis or if a person does less, gets paid less or has less

responsibility than during prior employment. Gainful work activity is the kind of work done for pay or profit whether or not a profit is realized.

3. Application of Standards – The disability determination standards that apply for Community Medicaid vary by age:
 - a. Persons age eighteen (18) or older. Disability determinations for applicants in this age group are made by the MART using the SSI criteria and standards. The determination is based on an assessment of whether the person seeking coverage is unable to engage in any substantial gainful activity due to any medically determinable physical or mental impairment, or combination of impairments, expected to result in death, or last or could be expected to last for a continuous period of not fewer than twelve (12) months. To meet this definition, there must be a severe impairment, which makes the person unable to do his or her previous work or any other substantial gainful activity existing in the national economy. To determine whether a person is able to do any other work, the MART considers residual functional capacity, age, education, and work experience.
 - b. Children under age nineteen (19) – MN Only. The MART is not usually responsible for making disability determinations for persons under nineteen (19). In general, these disability determinations are made formally by the SSA in conjunction with SSI eligibility, evaluations conducted by professionals for educational or child welfare services or through a qualified Medicaid provider. The SGA standard does not apply; however. The child must have a physical, mental, or behavioral health impairment, or combination of impairments, resulting in marked and severe functional limitations, expected to result in death or that have lasted or are expected to last for at least twelve (12) consecutive months. The MART may make such disability determinations for MN applicants under age nineteen (19) using the applicable SSI standards.
 - c. Disability based on Blindness. Applicants seeking eligibility for a disability based on blindness who do not qualify for SSI because their income is too high must meet the duration and SGA standard and have central visual acuity of 20/200 or less, even with glasses, or a limited visual field of twenty degrees (20°) or less in the better eye with the use of a correcting lens.
 - d. Working Persons with Disabilities – No LTSS. Applicants who have disabilities but who are working are exempt from the SGA step of the sequential evaluation of the disability determination. This exemption applies if the person otherwise meets the requirements set forth for coverage under the Sherlock Plan in the Medicaid

Code of Administrative Rules, Sherlock Program, or other related provisions for adults with disabilities.

1.10.3 MART Five Step Determination Process

- A. This subsection explains the five (5) step sequential review process the MART uses when determining whether an applicant who is age nineteen (19) or older meets the SSI disability criteria. When using the review process, the MART considers all the evidence in an applicant's case record in a series of sequential steps. Upon making a determination of disability at any step in the sequence, the review process stops and the MART does not proceed to the next step. If no determination is made, the MART proceeds from one step to the next in order until a decision is made. The steps are as follows:
1. Step One (1) – At the first (1st) step, the MART must consider the work activity of the person applying, if any. If the applicant is engaging in substantial gainful activity, he or she will be determined ineligible except in instances in which the provisions in the Medicaid Code of Administrative Rules, Sherlock Program, or related provisions apply, pertaining to Medicaid eligibility for working persons with disabilities.
 2. Step Two (2) – Upon proceeding to the second (2nd) step, the MART must consider the medical severity of a person's impairment(s). If the person does not have a severe medically determinable physical or mental impairment that meets the duration requirement set forth in the SSI disability rules, or a combination of impairments that is severe and meets the duration requirement, the person will be found not disabled.
 3. Step Three (3) – At the third (3rd) step, the MART must also consider the medical severity of the person's impairment(s). If the person has at least one (1) impairment that meets or equals one (1) of the listings in the SSI rules at 20 C.F.R. [Part 404](https://www.ssa.gov/OP_Home/cfr20/404/404-app-p01.htm), appendix 1 to subpart P (located at: https://www.ssa.gov/OP_Home/cfr20/404/404-app-p01.htm) and meets the duration requirement, the MART determines the person to be disabled for Medicaid eligibility purposes.
 4. Step Four (4)– The fourth (4th) step entails MART consideration of the required assessment of the person's residual functional capacity and past relevant work. If the person continues to perform past relevant work, the MART will find the person not disabled.
 5. Step Five (5) – At the fifth (5th) and last step, the MART considers the assessment of the person's residual functional capacity, age, education, and work experience to determine if the person is able to make an adjustment to other work. If a person is found to be able to make an adjustment to other work, the MART determines the person is not

disabled. If the person is not able to make such an adjustment to other work, the MART will find the person to be disabled.

1.10.4 Referral to the MART

- A. All adults over age nineteen (19) applying for Medicaid are evaluated by the Integrated Eligibility System using the MAGI standard before consideration using the SSI-methodology. The application includes questions about a person's need for care, previous or pending disability determinations and the need for retroactive Medicaid, which provides coverage for certain health expenses incurred in the three (3) months prior to making application.
1. Referral to the MART – Applicants who indicate on the Medicaid application that they have been determined to have a disabling condition by a government agency and/or are seeking retroactive eligibility are referred to the MART for a disability review if they:
 - a. Are not currently an SSI or RSDI recipient and do not qualify for MAGI-based coverage due to Medicare eligibility or enrollment and/or are seeking retroactive eligibility; or
 - b. Qualify for such MAGI coverage but would prefer to be evaluated for IHCC through a pathway for Community Medicaid.
 2. Limits on Referral –In accordance with federal regulations at 20 C.F.R. § 435.541, when a person is seeking Medicaid on the basis of a disability, the following limitations apply:
 - a. The MART may not make a determination of disability when the only application for benefits has been filed with the SSA.
 - b. The MART may not make an independent determination of disability if the SSA has made such a determination on the same issues presented in the Medicaid application within the ninety (90) day time limit allowed by federal regulations.
 - c. A determination of disability made by the SSA is binding. Accordingly, the MART, as a unit of the Medicaid Single State Agency, must refer to the SSA all applicants alleging new information or evidence affecting previous determinations of ineligibility based on disability for reconsideration or reopening of the determination except in cases specified in 20 C.F.R. § 435.541 (c)(4).
 3. These limits on referrals to the MART do not apply if the person is seeking Medicaid as a non-cash recipient with income above the SSI standard through the EAD pathway and the person has not applied for SSI cash benefits; has applied and has been found ineligible for SSI for a reason

other than disability; or the SSA has not made a determination on a disability related application within ninety (90) days from the date the application for Medicaid was filed with the SSA.

1.10.5 Continuing Eligibility for EAD Adults with Disabilities

- A. Continuing eligibility for beneficiaries eligible due to a disability is multifaceted.
1. Medicaid Renewal – Beneficiaries eligible through the EAD pathway on the basis of a disabling impairment are renewed on an annual basis in accordance with the provisions of [§ 00-2.7](#) of this Chapter, subject to periodic reviews by the MART.
 2. MART Periodic Reviews – These reviews must focus on whether there has been any medical improvement in a beneficiary’s impairment since the comparison point decision and, if so, whether the improvement is related to the beneficiary’s ability to work. For these purposes:
 - a. Comparison Point Decision (CPD). The most recent favorable decision which is the latest final determination or decision involving a consideration of the medical evidence and whether a person is disabled or continues to be disabled.
 - b. Medical Improvement. Any decrease in the medical severity of the impairment that was presented at the CPD as measured by changes in symptoms, signs and/or laboratory findings associated with the impairment.
 3. The MART must conduct these reviews in accordance with federal SSI regulations at 20 C.F.R. § 404.1594 and the schedule for conducting reviews identified at 20 C.F.R. § 416.990. This schedule indicates the reviews must generally be conducted as follows:
 - a. Impairment expected to improve – six (6) to eighteen (18) months from date of CPD;
 - b. Impairment not considered permanent, but medical improvement cannot be accurately predicted – once every three (3) years from CPD;
 - c. Impairment is considered permanent – at least once every seven (7) years, but not more often than once every five (5) years from CDP;
 - d. Immediately, for the reasons set forth in subsection (b) of the federal rule including, but not limited to: the beneficiary returns to work or is reported by government agency or other source to be able to begin working or no longer disabled, electronic data sources

indicating earnings increased substantially, or a self-reported recovery from the impairment.

4. Limitations – A periodic review is not required for any beneficiary with a disability determined by the SSA and/or authorized to work under the Sherlock Plan or any other eligibility pathway for adults with disabilities who are working as identified in this chapter.
5. The eligibility of Medicaid beneficiaries who are sixty-five (65) and older are renewed on an annual basis in accordance with the provisions located in [Subchapter 00 Part 2](#) of this Chapter.

1.10.6 Agency and Applicant Responsibilities

The applicant must provide the health care authorizations and information necessary to make a timely and accurate determination of disability. The MART is responsible for assuring that determinations are made in accordance with the federal Medicaid regulations at 42 C.F.R. § 435.541 and the disability criteria established by the SSA. The criteria used by the MART are located at: www.eohhs.ri.gov/ Federal requirements used by the SSA are located at <https://www.ssa.gov/disability/professionals/bluebook/> and may be obtained in hard copy by contacting the Social Security Administration, One Empire Plaza, 6th Floor, Providence, RI 02903 or 1-877-402-0808 (TYY 401-273-6648).

1.11 Financial Eligibility Determination

1.11.1 Scope and Purpose

To determine a person's eligibility using the SSI methodology, a comparison is made between the countable income and resources of the applicant's FRU and the income limits applicable to the Medicaid eligibility IHCC group. Once these groups have been established, financial eligibility is determined in accordance with the provisions for the SSI treatment of income and resources set forth in §§ [00-3.1 through 00-3.5](#) of this Chapter, and/or the special eligibility requirements in § 1.7 of this Part. This section focuses on the financial eligibility determination process for the Community Medicaid pathways in which the State is responsible for initial and continuing eligibility.

1.11.2 The Medicaid Eligibility Group

- A. The Medicaid eligibility group for Community Medicaid when determined by the state is as follows:
 1. Single Adults – A single adult requesting Community Medicaid, including Medicaid LTSS, is treated as an "individual" – that is – Medicaid eligibility group of one (1).

2. Groups for Adults with Spouses – When two (2) spouses are living together, both the person requesting Medicaid and the applicant’s spouse are considered members of applicant’s Medicaid eligibility group – a “couple” or group of two (2) – unless one (1) of the exceptions specified below applies. This is true whether or not the spouse is also requesting Medicaid.
 - a. Living together. A couple is also considered living together in any of the following circumstances:
 - (1) Until the first (1st) day of the month following the calendar month of death or marriage separation, that is, when one (1) spouse dies or the couple separates;
 - (2) When the number of days one (1) spouse is expected to receive LTSS in an institution or home and community-based setting is fewer than thirty (30) days; and
 - (3) When the resources of the couple are reassessed and allocated at the point in which the need for continuous LTSS is determined and an application for Medicaid coverage of LTSS is made as indicated in the Medicaid Code of Administrative Rules, Evaluation of Resources, and Resource Transfers.
 - b. Exceptions. Adult applicants with spouses are treated as an “individual” for eligibility purposes in the following circumstances:
 - (1) When one (1) spouse in a couple is receiving long-term care and applying for Medicaid LTSS, the applicant for Community Medicaid is treated as an “individual” – group of one (1) – for the determination of initial and ongoing income eligibility and resource reviews. The couple, whether or not still married, is treated as no longer living together as of the first (1st) day of the calendar month that the spouse receiving LTSS became eligible for Medicaid. This remains true even if the other spouse receiving Community Medicaid begins receiving Medicaid LTSS in a subsequent month.
 - (2) When both spouses receive Community Medicaid and are residing in a residential care setting serving four (4) persons or more, each spouse is treated as an individual without regard to whether they live together. This applies to Community Medicaid beneficiaries who do not qualify for LTSS while residing in licensed assisted living residences, behavioral health community residences, adult supportive

care homes, and supportive living arrangements for adults with developmental disabilities.

- c. Dependent child in the household. The Medicaid eligibility group increases in size for any dependent child under age nineteen (19) who is not receiving SSI.
3. Child (Applicable for MN Eligibility Only) – The Medicaid eligibility group for a dependent child up to age nineteen (19) applying for MN coverage using the SSI methodology is a group of one (1). Once reaching age nineteen (19), the rules related to a single adult apply.
4. Parent-Child – When a parent and dependent child living together are both seeking Medicaid in IHCC groups in which the SSI methodology applies, they are treated as two (2) Medicaid groups of one (1), if the parent is not living with a spouse. If the parent is living with a spouse, the parents are treated as a Medicaid group of two (2) and the child as a Medicaid group of one (1). When a parent/caretaker is seeking MN eligibility, any MAGI-eligible members of the household are excluded from the eligibility group.

1.11.3 Formation of the FRU

- A. The financial responsibility group (FRU) consists of the persons whose income and resources are considered available to the applicant or beneficiary in the eligibility determination. The FRU is relevant for deeming purposes for non-LTSS Medicaid and in determining eligibility for certain IHCC Community Medicaid coverage groups. The following subsections set forth the rules for determining membership in the FRU and the portion of income considered available to the person seeking Medicaid.
 1. FRU Composition for Citizens – The FRU for citizens and sponsored non-citizens differs due to deeming requirements. For citizens, the FRU consists of the person seeking Medicaid and, as appropriate, a spouse, parent, and/or dependent child. Other members of the household are not included in the FRU even if they make financial contributions.
 - a. FRU Single Adults. The FRU for an adult requesting SSI-related Medicaid, including Medicaid LTSS, is the same as the adult's Medicaid eligibility group.
 - b. FRU Child. The financial responsibility group for a dependent child includes the child and any parents living with the child, until the child reaches the age of nineteen (19) or twenty-one (21) if the child has a disabling impairment. A child's income is never deemed to parent. If the child is under age nineteen (19) and seeking Medicaid LTSS through the Katie Beckett eligibility pathway, the income and resources of the child's parents are deemed unavailable and the FRU is composed of the child only.

- c. FRU Couples. Except in instances in which a member of a couple is a Medicaid LTSS applicant or beneficiary, spouses are considered financially responsible for one another during the financial eligibility determination process. The FRU includes the applicant and spouse, even when the spouse is not applying for Medicaid (NAPP spouse, hereinafter). The child's income is never deemed to a parent or a sibling.
2. FRU for Sponsored Non-citizens – The FRU for a non-citizen admitted to the United States on or after August 22, 1996 based on a sponsorship under the Immigration and Nationality Act (INA), 8 C.F.R. § 204, includes the income and resources of the sponsor and the sponsor's spouse, if the spouse is living with the sponsor, when all four (4) of the following conditions are met:
 - a. The sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. Law. 104-193, (PRWORA) to conform to the requirements of 8 C.F.R. § 213A(b);
 - b. The non-citizen is lawfully admitted for permanent residence, and a five (5) year period of ineligibility for Medicaid following entry to the United States has ended;
 - c. The non-citizen is not battered; and
 - d. The non-citizen is not indigent, defined as unable to obtain food and shelter without assistance, because his or her sponsor is not providing adequate support.
 - e. The financial responsibility of a sponsor continues until the noncitizen is naturalized or credited with forty (40) qualifying quarters of coverage by the SSA. See:
<http://policy.ssa.gov/poms.nsf/lnx/0300301315>

1.11.4 General Rules for Counting Income – Community Medicaid

- A. For Community Medicaid, the determination of income eligibility using the SSI methodology follows a set sequence of calculations related to the application of exclusions and disregards as set forth in [§ 00-3.3](#) of this Chapter. Unearned income exclusions and disregards are applied first.
 1. Order of Unearned Income Exclusions and Disregards – Unearned income is countable as income in the earliest month it is received by the person; credited to a person's account; or set aside for the person's use. The order for applying exclusions and disregards is as follows:

- a. Federal law. Exclusions mandated in federal law or regulations as set forth in [§ 00-3.4](#) of this Chapter are applied first unless indicated otherwise.
- b. Medicaid. The following types of unearned income are excluded or disregarded in the order indicated:
 - (1) Any refund of taxes;
 - (2) Assistance based on need which is provided under a program which uses income as a factor of eligibility and is wholly funded by the State or a local government. General Public Assistance (GPA) and the optional State Supplemental Payment (SSP) for SSI beneficiaries and SSI-lookalikes are examples of excluded payments in this category.
 - (3) Grants, scholarships, fellowships, or gifts used for paying educational expenses are excluded or countable depending upon their use:
 - (AA) Any portion of a grant, scholarship, fellowship, or gift used for paying tuition, fees, or other necessary educational expenses at any educational institution, including vocational or technical education institutions, is excluded from income.
 - (BB) Any portion of such educational assistance that is not used to pay current tuition, fees or other necessary educational expenses but is set aside to be used for paying this type of educational expense at a future date is excluded from income in the month of receipt. If these funds are not spent after nine (9) months, they become a countable resource the first (1st) day of the tenth (10th) month following receipt.
 - (CC) Any portion of a grant, scholarship, fellowship, or gift that is not used or set aside for paying tuition, fees, or other necessary educational expenses is income in the month received and a resource the month after the month of receipt if retained.
 - (4) Food which a person or his/her spouse raises if it is consumed by the household;
 - (5) Assistance received under the [FEMA Disaster Assistance Reform Act of 2015, H.R. 1471](#), (as in effect on February 1,

2016), and assistance provided under any federal statute because of a presidentially declared disaster;

- (6) The first sixty dollars (\$60) of infrequent or irregular unearned income received in a calendar quarter;
- (7) Alaska longevity bonus payments;
- (8) Foster care payments that are not funded through Section IV-E;
- (9) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become a part of that burial fund;
- (10) Support and maintenance assistance based on need:
 - (AA) Provided in-kind by a private nonprofit agency; or
 - (BB) Provided in cash or in-kind by a supplier of home heating oil or gas, or by a private or municipal utility company.
- (11) One-third (1/3) of child support payments made by a non-custodial absent parent, unless exempt in accordance with [§ 00-3.3](#) of this Chapter;
- (12) Twenty dollar (\$20.00) general income disregard. The disregard does not apply to program payments when income is used as an eligibility factor and the payment is wholly or partially funded by the federal government or by a non-governmental agency such as Catholic Charities or the Salvation Army.
- (13) Unearned income used to fulfill an approved plan to achieve self-support (PASS);
- (14) Federal housing assistance provided by:
 - (AA) An office or program of the U.S. Department of Housing and Urban Development (HUD); or
 - (BB) The U.S. Department of Agriculture's Rural Housing Service (RHS), formally known as the Farmers Home Administration (FHA);

- (15) Any interest on excluded burial space purchase agreement if left to accumulate as part of the value of the agreement;
- (16) The value of any commercial transportation ticket which is received as a gift and is not converted to cash;
- (17) Payments from a State compensation fund for victims of crime;
- (18) Relocation assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 in accordance with 42 U.S.C. § 301 (as in effect on February 1, 2016) provided to individuals displaced by any federal or federally-assisted project or state or local government or through a state-assisted or locally-assisted project involving the acquisition of real property;
- (19) Combat fire pay received from the uniformed services;
- (20) Interest on a dedicated account in a financial institution, the sole purpose of which is to receive and maintain past-due SSI benefits which are required or allowed to be paid into such an account, and the use of which is restricted by 42 U.S.C. § 1631(a)(2)(F);
- (21) Gifts to children with life-threatening conditions from an organization described in § 501(c)(3) of the Internal Revenue Code of 1986, [Pub. Law. 99-514](#), (as in effect on February 1, 2016), within the following limitations:
 - (22) In-kind gifts are not converted to cash;
 - (23) No more than the first two thousand dollars (\$2,000) of any cash gifts within a calendar year may be excluded;
 - (24) Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than 42 U.S.C. § 1613(a) (as in effect on February 1, 2016);
 - (25) An annuity paid by a state, to a person and/or the person's spouse, on the basis of the state's determination that the person is a veteran and is blind, sixty-five (65) or older and/or living with a disabling impairment.

2. Order of Earned Income Exclusions – In general, earned income disregards and exclusions are applied in the following order:

- a. Federal law. Exclusions mandated in federal law or regulations as set forth in [§ 00-3.4](#) of this Chapter are applied first, unless indicated otherwise.
 - b. SSI Methodology. The following types of earned income are excluded or disregarded in order:
 - (1) Earned income tax credit payments and child care tax credit payments;
 - (2) The first thirty dollars (\$30) of infrequent or irregular earned income received in a calendar quarter;
 - (3) Student earned income exclusion (SEIE) up to the monthly limit, and not more than the yearly limit as indicated in [§ 00-3.1.7](#) of this Chapter.
 - (4) Any portion of the twenty dollars (\$20) monthly general income disregard which has not been excluded from unearned income in that same month;
 - (5) The first sixty-five dollars (\$65) of earned income in a month;
 - (6) Earned income of a person with disabilities used to pay impairment-related work expenses (IRWEs), as described in 20 C.F.R. § 404.1576;
 - (7) One-half (1/2) of remaining earned income in a month;
 - (8) Work expenses of a person who is blind;
 - (9) Earned income used to fulfill an approved plan to achieve self-support (PASS).
3. Unused exclusions and disregards – When calculating countable income, the limitations below apply:
- a. Exclusions never reduce earned or unearned income below zero (0).
 - b. Unused portions of a monthly disregard or exclusion cannot be carried over for use in subsequent months.
 - c. Unused earned income disregards and exclusions are never applied to unearned income.

- d. Other than the twenty dollars (\$20) general income disregard, no unused unearned income exclusion may be applied to earned income.
- e. The twenty dollars (\$20) general and sixty-five dollars (\$65) earned income exclusions are applied only once to a couple, even when both members have income, since the couple's earned income is combined in determining Medicaid eligibility.

1.11.5 Income Deeming

- A. To deem income is to attribute one (1) person's countable income in the calculation of another person's countable income. Income deeming requirements are based on the FRU rather than the Medicaid eligibility group rule. A person may be included in the Medicaid eligibility group without being included in the FRU – (e.g., the sibling of a child seeking MN eligibility –) and having their income deemed to an applicant or non-applicant in the household. The general rules for determining countable income related to the application of earned and unearned income exclusions identified above in § 1.11.4 of this Part are applied. In addition:
 - 1. The person seeking initial or continuing Medicaid eligibility is referred to as the “applicant”; members of the household who are not covered by or applying for Medicaid are referred to in this subsection as “non-applicants” or NAPPs.
 - 2. Whose income is deemed to an applicant is determined separately for each member of the FRU.
 - 3. Income based on need, in which income is a factor in determining eligibility, provided by any local, state or federal agency and any income which was taken into account in determining eligibility and which affected the amount of such assistance or payment is excluded in the income deeming process, unless specifically indicated otherwise. Includes: SSI; SSP; RI Works and GPA cash assistance; Veteran's Administration (VA) pensions; or in-kind support and maintenance.
- B. Spouse-to-Spouse – Except as indicated in the situations noted below, the income of a NAPP spouse is deemed to an applicant if the spouses live together. If an applicant is not divorced but is legally separated from his or her spouse, and continues to live in the same household, the NAPP spouse's income is deemed. In the following situations, spouse-to-spouse income deeming does not apply:
 - 1. The spouses do not live together.
 - 2. The applicant is seeking coverage under the Sherlock Plan as a working adult with a disability in accordance with the Medicaid Code of Administrative Rules, Sherlock Plan.

- a. Deeming. The amount of income that is deemed to the applicant spouse is calculated by subtracting from the NAPP spouse's gross income:
 - (1) An amount equal to the deeming standard for each dependent child in the household. The "deeming standard" is the difference between the Federal Benefit Rate (FBR) for a couple and the limit for a single person, as indicated in [§ 00-3.1.7](#) of this Chapter, less any countable income from the child. The difference between the two is the living allowance for the NAPP child, as indicated herein.
 - (2) Any portion of the NAPP spouse's income paid in court-ordered child support for a child living in another household.
 - (3) Exclusions and disregards that apply when calculating countable income for the applicant spouse.
 - (4) If the NAPP spouse's remaining income after exclusions and disregards are applied is greater than the deeming standard, then the couple's income is calculated according to the general rules for determining countable income using SSI methodology. That income is then compared against the Medicaid eligibility group income limit for the family size involved – i.e., household size.
- b. Treatment of deemed income. The deemed amount is counted as unearned income in determining the applicant's income eligibility for Medicaid.

C. Parent-to-Child – Except in the situations noted below for MN eligibility, the income of a biological or adoptive parent is deemed to a child who is under age eighteen (18) and living with a parent as long as the child has not been legally emancipated. When the father is not married to the child's mother, the father's income is only deemed to the child if they reside together and paternity has been established.

1. In the following situations, the income of a parent is NOT deemed to a child:
 - a. The child is not eligible for SSI, but is participating in a foster care or adoption subsidy program administered by the State.
 - b. The child is seeking LTSS through the Katie Beckett eligibility option in accordance with the Medicaid Code of Administrative Rules, Global Consumer Choice Waiver.

2. Deeming Rules: The amount of income deemed from parent to child requires a multi-step calculation of income that must be followed in the sequence below:
 - a. The earned and unearned income of the parents of the applicant child is calculated allowing the standard exclusions EXCEPT for the standard twenty dollar (\$20) and sixty-five dollar (\$65) plus one-half (1/2) disregards.
 - b. The living allowance allocated to NAPP children is determined by multiplying their number by the deeming standard. Any children receiving SSI or RI Works cash assistance are not included in this calculation. The income of each NAPP child is deducted from this sum, if any.
 - c. The total of the unearned income of the parents is calculated and then any remaining allowance for NAPP children in the household not met by their own income is subtracted.
 - d. The earned income of the parents is totaled and any remaining living allowance for NAPP children is subtracted. If there is no remainder, there is no income to deem. If there is income remaining, deeming is applicable.
 - e. Deemed income from parent to child is then calculated by: deducting the twenty dollar (\$20) income disregard from any remaining parental unearned income; subtracting sixty-five dollar (\$65), plus any of the remainder of the twenty dollar (\$20) disregard and one-half (1/2) of the still remaining parental earned income. The remaining unearned and earned income is added and, from this total, so too is the individual FBR (for a one (1) parent household) or the couple FBR (for a two (2) parent household).
 - f. The remaining income is deemed to be unearned income to the child. Note: If more than one (1) child is applying, deemed income is divided equally.
- D. Other Household Members – When determining a person’s initial or continuing eligibility, income is NOT deemed from a:
 1. Child to a parent;
 2. Sibling to another sibling, or other children under twenty-one (21) living in the household;
 3. Stepparent to a stepchild;
 4. Grandparent to a grandchild; or

5. Relative caretaker to a child.
- E. Sponsor Deeming – Sponsor deeming rules apply to non-citizens who are sponsored by one or more individuals under a signed Affidavit of Support (USCIS I-1864), unless one (1) of the following exceptions applies.
1. Exceptions to Sponsor Deeming. Sponsor deeming does not apply to sponsored non-citizens when:
 - a. The non-citizen is under age twenty-one (21).
 - b. The non-citizen is pregnant. This exception ends when the sponsored pregnant woman's sixty (60) day postpartum period ends. Sponsor deeming applies the month following the end of the postpartum period.
 - c. The non-citizen has sponsorship deferred by USCIS when their immigration status is changed to "Battered Non-citizen."
 - d. If the non-citizen needs placement in a facility and placement is jeopardized by the sponsor's failure or inability to provide support, or inability of the non-citizen to locate the sponsor.
 2. General rules of sponsor deeming. Income of a sponsor and the sponsor's spouse is deemed to each non-citizen covered by the affidavit regardless of whether the sponsor actually contributes to the non-citizen's support and maintenance needs. Income is deemed even if the sponsor or the sponsor's spouse is receiving public assistance in Rhode Island or another state. The following types of income of the sponsoring individual/couple are deemed:
 - a. Gross income, including any cash assistance received by the sponsor or the sponsor's spouse;
 - b. Net self-employment income, minus self-employment expenses;
 - c. If the sponsor is a member of the FRU, the sponsor's income is already deemed to the sponsored non-citizen spouse and family members in accordance with income deeming rules contained in § 1.11.5(E) of this Part.
 3. If the sponsor is not a member of the FRU or is a member of the Medicaid eligibility group whose income is not deemed under income deeming rules § 1.11.5(E) of this Part, the following apply:
 - a. The total gross income of the sponsor and the sponsor's spouse is deemed to each sponsored non-citizen.

- b. The sponsor or the sponsor's spouse's income are considered available and are not excluded.

1.11.6 General Rules for Counting Resources – Community Medicaid

- A. The State uses a more simplified process for counting resources for Community Medicaid, as explained in [§ 00-3.5.1](#) of this Chapter, which permits attestations about the value of certain resources during the application process when determining financial eligibility. For Medicaid LTSS eligibility, full verification of resources and a transfer of asset review are required for IHCC group members prior to the determination of eligibility and authorization of services. There is no review of the transfer of assets for Community Medicaid.
 - 1. Process – The process rules identified in [§ 00-3.6.2](#) of this Chapter are used in evaluating resources to determine which are included in the calculation.
 - 2. Application of Exclusions – Both federally mandated and program specific exclusions are applied for resources of a Community Medicaid applicant or beneficiary, the following items are excluded in the following order in the amounts indicated:
 - a. The home and adjoining land;
 - b. Household goods and personal effects;
 - c. One automobile and the equity value of a second (2nd) vehicle above four thousand five hundred dollars (\$4,500);
 - d. Property of a trade or business which is essential to the means of self-support;
 - e. Non-business property which is essential to the means of self-support;
 - f. Resources of person who is blind or living with a disabling impairment which are necessary to fulfill an approved PASS;
 - g. Stock in regional or village corporations held by natives of Alaska during the twenty (20) year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act; 43 U.S.C. 1601-1624,
 - h. Whole life insurance owned by a person and/or spouse but only when the combined face value of all policies per person is at or below one thousand five hundred dollars (\$1,500) for EAD or four thousand dollars (\$4000) for medically needy;

- i. Restricted allotted Indian lands;
- j. Payments or benefits provided under a federal statute other than Title XVI (OASDI, including RSDI and SSD) of the Social Security Act, 42 U.S.C. § 1381-1383f, where an exclusion is required by such statute as indicated in [§ 00-3.6](#) of this Chapter;
- k. Disaster relief assistance;
- l. Burial expense funds and set asides to the extent allowed up to one thousand five hundred dollars (\$1,500) for EAD and four thousand dollars (\$4,000) for persons who are MN;
- m. Title XVI (OASDI) or Title II (SSI) of the Social Security Act, 42 U.S.C. §§ 1381-1383f, retroactive payments;
- n. Housing assistance;
- o. Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit;
- p. Payments received as compensation for expenses incurred or losses suffered as a result of a crime;
- q. Relocation assistance from the State or a local government;
- r. Dedicated financial institution accounts;
- s. Gifts to children under age eighteen (18) with life-threatening conditions;
- t. Restitution of SSI, Title VIII, 42 U.S.C. § 1001-1013, or RSDI benefits because of misuse by certain representative payees;
- u. Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses;
- v. Payment of a refundable child tax credit, as provided; and
- w. Any annuity paid by a state to a person (or his or her spouse) based on the State's determination that the person is a veteran (as defined in 38 U.S.C. § 101) and blind, living with a disabling impairment, or aged.

1.11.7 Resource Deeming

- A. To deem resources is to count one (1) person's resources in the calculation of another person's countable resources. As with income deeming, resource

deeming requirements apply to members of the FRU, which is not always the same as the Medicaid eligibility group. Only the resources of the applicant's spouse or the parent(s) of a child are considered for the purposes of deeming resources. The deeming process proceeds as follows:

1. Spouse-to-Spouse – In deeming resources from one (1) spouse to the other, only the resources of the couple are considered.
 - a. Living together. When an applicant and NAPP spouse live together, all resources are combined and the couple is permitted resources up to the amount allowed for the Medicaid eligibility group of two (2). The couple's resource limitation is not affected by whether the spouse of the applicant is applying for or receiving Medicaid or is a non-applicant.
 - b. Living apart. When an applicant and spouse are no longer living together, each person is considered as an individual living alone beginning the month after separation and the individual resource limit applies. For the month of separation, the spouses are treated as a couple, as long as they were living together at some point during the month.
2. Single individual – When an applicant is not living in a home with a spouse or parent(s), only the resources of the applicant are considered. The resource limits for an “individual” or Medicaid eligibility group of one (1) apply.
3. Parent-to-child – In deeming resources from a parent to a child, the resources of a child consist of whatever resources the child has in his or her own right plus whatever resources are deemed to the child from his or her parent(s).
 - a. In determining the amount of resources to be deemed to an applicant child, the resources of the child and of the parents are computed separately and both the child and the parents are each allowed all of the resource exclusions they would normally be eligible to receive in their own right. Only one (1) home and one (1) vehicle are completely excluded, however. The equity value of a second (2nd) vehicle is counted in accordance with [§ 00-3.5.5\(A\)\(1\)\(d\)](#) of this Chapter.
 - b. It does not matter whether a parent(s) is or is not eligible for Medicaid.
 - c. After the exclusions are applied, only the countable resources over the resource exclusion of the parent(s) living in the home are deemed to the child when there is only one (1) child.

- d. When there is more than one (1) applicant/eligible child, the resources available for deeming are shared equally among the eligible children.
- e. None of the parents' resources are deemed to any other non-applicant/ineligible children.
- f. A child is not eligible for Medicaid as MN if his or her own countable resources plus the value of the parents' resources deemed to the child exceed the resource limit for an individual – Medicaid Eligibility group of one (1) – of four thousand dollars (\$4,000).