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TITLE 210 – Executive Office of Health and Human Services

CHAPTER 50 - MEDICAID LONG-TERM SERVICES AND SUPPORTS (LTSS)

Subchapter 00 - N/A

PART 3 - ELIGIBILITY PATHWAYS

3.1 Overview

A. Eligibility for LTSS Medicaid coverage is based generally on the need for care and its affordability given a person's finances. Under applicable federal regulations, some of the specific requirements for Medicaid LTSS vary depending on eligibility pathway. Income and resource standards differ as do the methods used to determine financial eligibility. Application processing timelines and service delivery options also vary. The distinctions are important, though the scope of Medicaid LTSS services and supports a person receives is always a function of need.

3.2 Scope and Authority

The purpose of this section is to identify the unique requirements for Medicaid LTSS coverage across eligibility pathways. Under Title XIX, the federal Medicaid law, an applicant for LTSS must be either a current beneficiary or possess an income, clinical, or age-related characteristic with an IHCC or MACC group and have an established need to qualify to apply. This section includes the general criteria for establishing need and, along with the eligibility pathways, the sequence in which LTSS eligibility determinations occur.

3.3 Qualifying for Medicaid LTSS

A. To qualify for Medicaid coverage of LTSS, a person must have received at least a base level of coverage or established a need for institutional care.

1. Base LTSS coverage – Under the Medicaid State Plan all beneficiaries, both MACC and IHCC group members, are eligible for up to thirty (30) days of base LTSS coverage in a health care institution.

    a. Beneficiaries enrolled in Medicaid managed care receive base coverage through their health plans.

    b. Beneficiaries receiving Medicaid through fee-for-services must obtain such services through an appropriately certified provider.

c. Both existing beneficiaries and new applicants must have established a need for LTSS, that is, be considered "institutionalized" to qualify for Medicaid LTSS once this base coverage is exhausted.

2. Established Need – Medicaid LTSS is available to new applicants and existing beneficiaries who have an established need for continuing services. This need in previous RI Medicaid rules was referred to as "considered institutionalized" for the purposes of determining Medicaid LTSS eligibility. Applicants/existing beneficiaries are considered to have such a need if they have received the level of services typically provided in a NF, ICF-ID, or long-term hospital setting for at least thirty (30) consecutive days and are expected to have a continued need for such services or have:

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

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

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

3.4 Eligibility Determination Process

A. There is a multiphase process for determining eligibility and authorization for Medicaid LTSS that proceeds as follows:

1. Information, Referral, Options Counseling – Prior to initiating the application process and/or at any step during the eligibility determination sequence, applicants and/or their family members or authorized representatives may seek information, referral and/or options counseling to assist them in navigating the LTSS system. Prior to the authorization of services and the post-eligibility treatment of income, an applicant/beneficiary must know what types of services, such as institutional or HCBS, will be covered and the LTSS living arrangement of choice. LTSS specialists from across the EOHHS agencies and various contractual agents are an important source of information, referral and counseling that can assist an applicant/beneficiary in making reasoned choices before and at each step in the eligibility determination process.

2. Eligibility Determination Sequence – To gain access to LTSS, the information provided by applicants is evaluated in the following steps:

a. General eligibility. All persons seeking initial or continuing Medicaid LTSS must meet the general requirements for the program and provide the necessary consent for electronic data matches for verifying income and resources and the authorizations necessary to obtain and review clinical information. See the Medicaid Code of Administrative Rules "Application Process" (Section 1303) and Part 3 of Chapter 40 of this Title for specific requirements.

b. Income and resource eligibility. The second step in the determination process is the consideration of income and, as appropriate, resources. This process differs for new applicants and current Medicaid beneficiaries seeking LTSS coverage as follows:

(1) New applicants. A new applicant is a person who is not currently receiving non-LTSS health coverage through either an IHCC or MACC group. When applying for Medicaid LTSS, all new applicants are evaluated first using the MAGI method to determine whether eligibility in the MACC group for adults exists, in accordance with the provisions set forth in the Medicaid Code of Administrative Rules "Determination of Income Eligibility" (Section 1307). Children seeking LTSS coverage are also evaluated first for MAGI eligibility under the applicable income eligibility standard for MACC group coverage (261 % of the FPL as indicated in the Medicaid Code of Administrative Rules "Eligibility Requirements" (Section 1305).

(2) If an applicant requesting LTSS is found ineligible for the applicable MACC group or is requesting retroactive coverage, the SSI method is used to evaluate income and resources. The Katie Beckett income eligibility process, which uses the SSI method, is the basis for evaluating income for children seeking Medicaid coverage for LTSS who do not qualify based on the MAGI. Deeming of income and resources does not apply when determining eligibility for LTSS.

(3) Beneficiaries with eligibility based on the participation of another program, including beneficiaries eligible for Medicaid based on SSI, or participation in a RI Department of Children, Youth, and Families (DCYF) program are not subject to an income eligibility determination.

(4) Current Beneficiaries. IHCC group beneficiaries seeking Medicaid LTSS are referred for a determination of clinical eligibility while a review of financial eligibility is conducted. MACC group beneficiaries seeking LTSS are subject to a full

determination using the SSI method if they are seeking retroactive coverage, before clinical eligibility is evaluated.

c. Clinical eligibility. Once income eligibility is established, an evaluation of clinical eligibility must be conducted for persons seeking Medicaid LTSS, without regard for eligibility pathway. The clinical eligibility determination is based on needs-based criteria that assess clinical, functional, social and behavioral needs as well as environmental factors. A Medicaid Assessment and Review Team (MART) determination of disability status is not required unless the applicant is seeking LTSS coverage while working through the Sherlock Plan. The assessment tool and criteria vary for each institutional level of care, as indicated in Part 1 of Subchapter 05 of this Chapter. Responsibility for clinical determinations is as follows:

(1) The Office of Medical Review (OMR) is responsible for clinical eligibility evaluations for persons seeking Medicaid coverage of LTSS typically provided in a NF and long-term hospital care.

(2) BHDDH conducts clinical eligibility determinations for persons who have a need for a level of care provided in an ICF-ID through the agency's program for adults with development disabilities as well as for certain persons with serious behavioral health needs who might require a hospital level of care.

(3) The DCYF may also evaluate clinical eligibility for children in State custody who may need the equivalent of an institutional level of care.

(4) The Katie Beckett Review Team determines clinical eligibility for children seeking coverage of LTSS under the Katie Beckett provisions. Continuing eligibility for current beneficiaries is based on the method used to determine initial eligibility and, if no basis for coverage is found, across the remaining pathways.

d. Transfer of assets. The determination of financial eligibility for Medicaid LTSS requires that the State review whether an applicant has transferred assets – income and/or resources – at or in the period before the need for LTSS was established in a manner inconsistent with federal and State laws and requirements.

e. Post-eligibility Treatment of Income (PETI). Under the State's Section 1115 waiver, all LTSS beneficiaries are subject to the PETI

process. Upon determining that a prospective beneficiary meets all other financial and clinical eligibility criteria, income and resources are evaluated a second time for the purposes of establishing income required for personal maintenance, the amount of the community spouse/dependent allowance, and a beneficiary's liability to pay toward the cost of care. This process takes into account the beneficiary's choice of services setting and person-centered planning if HCBS is involved and aspects of the authorization process. The process also considers whether outstanding or pending health care expenses of the applicant may be "allowable" as expenses to reduce income. This process is an important component of the financial eligibility determination for applicants/beneficiaries who have high outstanding health care costs for services that, meet certain requirements, but are not covered by Medicaid and will affect the availability of countable income, as indicated in Part 8 of this Chapter.

3. Services Plan and Authorization of LTSS – Development of a service plan and authorization of Medicaid LTSS is required before a payment is made for coverage provided to a beneficiary. The purpose of this process is to ensure that a beneficiary is or will be able to attain the full scope of services required to meet his or her needs in the choice of LTSS living arrangement. Toward this end, LTSS specialists from across the EOHHS agencies and their community partners and contractual agents consider the results of the clinical eligibility needs-based assessment, more intensive evaluations, as appropriate, and/or the consensus decisions made in the person-centered planning process for HCBS or the results of the Pre-admission Screening and Resident Review (PASRR) for nursing facility care to help ensure that every beneficiary receives the right services, at the right time, and in the most appropriate setting.

3.5 Eligibility Pathways

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

1. SSI and SSI-related Groups – SSI recipients and members of certain SSI-related groups are automatically eligibility for Medicaid based on a determination by SSA as indicated in Part 3 of Chapter 40 of this Title. Federal regulations at § 42 CFR 435.603 (j) specifically exclude Medicaid determinations of eligibility for members of this group, including for LTSS, using the MAGI standard except in instances in which an SSI recipient no longer meets disability criteria and loses cash assistance on this basis. Special provisions also apply to SSI-eligible Medicaid LTSS beneficiaries

who are expected to need LTSS coverage for ninety (90) days or less. Accordingly, access to LTSS proceeds as follows:

a. Eligibility Criteria. Beneficiaries eligible on the basis of SSI who need LTSS must meet the clinical eligibility disability requirements for an institutional level of care set forth in Part 1 of Subchapter 05 of this Chapter as well as the financial eligibility criteria related to the transfer of assets. The resource limit is set at $2,000.

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

(1) SSI recipients who have § 1619 (b) status, as indicated in § 1.5.4 of Subchapter 05 Chapter 40 of this Title remain eligible for two (2) months of continuing cash assistance benefits if admitted to Eleanor Slater Hospital;

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

c. Determination Process. SSI recipients are not subject to a MAGI determination and a re-evaluation of income/resource eligibility using the SSI method is not required. LTSS eligibility involves the review of clinical eligibility, the transfer of assets, and PEME and PETI steps in the eligibility determination sequence. Special rules applicable to the treatment of SSI income apply as indicated in Part 3 of Chapter 40 of this Title. Authorization of services proceeds as specified in § 3.4 (A)(3) of this Part.

d. Retroactive Coverage. Beneficiaries eligible for Medicaid LTSS on the basis of SSI are eligible for up to three (3) months of retroactive coverage.

e. Continuing eligibility. Eligibility factors subject to review in the renewal process are the same as those that serve as the basis for eligibility.

2. Adults 19 to 64 – All persons seeking initial or continuing eligibility for Medicaid LTSS in this age group are evaluated as follows:

a. Eligibility Criteria. All persons seeking Medicaid LTSS must meet the general eligibility requirements clinical eligibility requirements and the standard PEME, PETI and Transfer of Assets criteria in the determination sequence. The income and/or resource requirements vary across pathways including:

(1) MACC Group for Adults: Income limit -133 percent of the FPL; No resource limit.

(2) IHCC Group Community Medicaid: Income limit – 100% of the FPL; Resource Limit – $4,000.

(3) Special Income/1915 Lookalikes: Income limit – 300% of the SSI standard; Resource Limit – $4,000

(4) Medically Needy: Income limit – Cost of Care; Resource Limit – $4,000

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

(1) MACC Group for Adults: Pathway closed to persons who are 65 and older or who are eligible for or enrolled in Medicare.

(2) IHCC Group Community Medicaid: Current beneficiaries may request to be assessed for preventive level services and by-pass the full sequence of financial eligibility reviews until such time as needs require re-evaluation for a "high" or the "highest" level of institutional care.

(3) Special Income: Pathway for persons who are in the IHCC medically needy group and adults 65 and under who do not qualify for IHCC Community Medicaid based on income.

(4) 1915 Lookalikes: Reserved for persons seeking Medicaid LTSS in the HCBS who would, absent these services, have the "high" or "highest" need for an institutional level of care. Generally, these are new applicants for Medicaid.

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

c. Determination Process. The principal distinction in the determination process aside from the difference in eligibility criteria is the method for evaluating income – MAGI v. SSI – and whether a

person is a new applicant or current Medicaid beneficiary determining eligibility.

(1) New Applicants for Medicaid. New applicants under age 65 are evaluated for the MACC group for adults first and, if found eligible on this basis, must provide information related to resources for the transfer of asset review. The eligibility sequence proceeds accordingly thereafter through the clinical eligibility determination process and PEME and PETI reviews. New applicants who are not eligible for the MACC group for adults, due to Medicare enrollment or eligibility, are automatically evaluated for LTSS using the SSI method with respect to income and resources and then proceed through the remaining steps in the LTSS eligibility sequence through to denial or approval of eligibility and authorization of services.

(2) Current Medicaid Beneficiaries. All beneficiaries in the IHCC and MACC groups can initiate the LTSS eligibility determination by reporting a change in their online account through the self-service portal or by seeking the assistance of an LTSS specialist in-person, by telephone, or through the U.S. Mail. The LTSS eligibility process begins by reviewing existing information related to income and resources and generating a task to LTSS eligibility specialists for a referral for a clinical eligibility determination and the remaining financial eligibility reviews – resource transfers, PEME, and PETI. IHCC group beneficiaries receiving preventive level services are referred directly for a clinical eligibility reassessment upon providing notification of an increase in need based on functional or health status.

d. Retroactive Coverage. Retroactive coverage is available for LTSS applicants evaluated on the basis of the SSI method. Accordingly, MACC group adults eligible for Medicaid LTSS do not have access to retroactive coverage. Coverage begins on the first day of the month in which an application or account change request is submitted.

e. Continuing Eligibility. The eligibility of all Medicaid beneficiaries is renewed on an annual basis. The renewal process includes a reassessment of clinical eligibility using the applicable needs-based criteria unless an exemption required in State or federal law or regulations applies. The clinical eligibility for Medicaid LTSS beneficiaries participating in BHDDH programs for persons with developmental disabilities is conducted in accordance with agency rules. A modified active renewal process is used for Medicaid

LTSS as information related to changes in functional and health status as well as income and resources may need to be provided by a beneficiary before a final determination of continuing eligibility is rendered.

f. Summary. The table below summarizes the areas where distinctions across eligibility pathways for adults 19 to 64 occur; that is, continuing eligibility is excluded as there are no pathway specific distinctions:

Variations in LTSS Eligibility Pathways for Adults 19 to 64

Eligibility Pathway	Eligibility Criteria		Special Conditions	Determination Process	Retroactive Coverage?
	Income Limits	Resource Limits			
MACC Adult Group	133% FPL with 138% ceiling	None	Eligibility or enrollment in Medicare is a bar to access as indicated in MCAR, Section 1305.	MAGI-based determination in accordance with provisions of Section MCAR, 1307.	No
IHCC Group for Elders and Adults with Disabilities (EAD)	100% FPL	$4,000	If currently receiving preventive level services referred directly for clinical eligibility reassessment.	SSI-based determination in accordance with provisions in MCAR, Section 140?	Yes
Special Income	100% FPL up to 300% SSI standard	$4,000	IHCC group medically needy pathway and for other persons with countable income above 100% FPL	SSI-based determination in accordance with provisions in MCAR, Section 140?	Yes
1915 Lookalike	100% FPL up to 300% SSI standard	$4,000	1915 Lookalikes is reserved for persons seeking HCBS	SSI-based determination in accordance with provisions in MCAR, Section 140?	Yes
Medically Needy	Above 300% of SSI standard	$4,000	Income cannot exceed average cost of care	SSI-based determination in accordance with provisions in MCAR, Section 140o and Section 1502	Yes

3. Elders 65 and older – The eligibility pathways for persons sixty-five (65) years of age and older vary somewhat when compared to those available for persons between 19 and 64 as specified above. The chief distinction is

that members of this population are not evaluated for MAGI-based eligibility even if they are the parents/caretakers of a Medicaid eligible child. New applicants and current beneficiaries are evaluated differently as with all other person seeking Medicaid LTSS coverage. Differences in criteria by pathway are as follows:

a. Eligibility Criteria. All persons seeking Medicaid LTSS must meet the general and clinical eligibility requirements and the standard PEME, PETI and Transfer of Assets criteria in the determination sequence. Although the income requirements vary, the resource limit is $4,000 for an individual applicant across pathways:

(1) IHCC Group Community Medicaid: Income limit – 100% of the FPL.

(2) Special Income/1915 Lookalikes: Income limit – 300% of the SSI standard.

(3) Medically Needy: Income limit – Cost of Care.

b. Special Conditions. The eligibility pathways for elders have few special conditions as the MACC group pathway is excluded. However, there are several that apply across populations:

(1) IHCC Group Community Medicaid: Current beneficiaries may obtain preventive level services without LTSS financial eligibility review and may be referred on that basis for an LTSS clinical eligibility review without first being evaluated for income and resources. Upon applying for LTSS, all other steps in the financial eligibility determination must be completed before coverage is authorized.

(2) Special Income: Pathway for persons who are in the IHCC medically needy group and adults 65 and older who do not qualify for IHCC Community Medicaid based on income.

(3) 1915 Lookalikes: Reserved for persons seeking Medicaid LTSS in the HCBS who would, absent these services, have the "highest" need for an institutional level of care.

(4) Medically Needy: Special rules for the treatment of income apply based and financial eligibility requires that, subsequent to the application of all regular and special disregards, income must be below the average cost of care in the applicable institutional setting, as set forth in in Part 1 Subchapter 05 of this Chapter.

c. Determination Process. The principal distinction in the determination process for members of this population is also a function of whether a person is a new applicant or current Medicaid beneficiary. However, a MAGI-based initial determination of income eligibility is excluded.

(1) New Applicants for Medicaid. New applicants 65 and older are evaluated first using the SSI method for the IHCC groups set forth in Part 3 Chapter 40 of this Title, with respect to the treatment of income and resources, unless special exceptions apply, as outlined in Part 6 of this Chapter. A referral for clinical eligibility is made subsequent to this evaluation in addition to a review of financial eligibility through each step in the determination sequence.

(2) Current Medicaid Beneficiaries. IHCC group beneficiaries apply for LTSS by reporting a change in their online account, as noted for adults 19 to 65 above. Once this process is initiated, a referral is made through the eligibility system for a clinical eligibility determination and the next steps in the financial eligibility review process.

d. Retroactive Coverage. Retroactive coverage is available for LTSS applicants evaluated on the basis of the SSI method. Accordingly, all elders are eligible for retroactive coverage.

e. Continuing Eligibility. The eligibility of Medical beneficiaries in this populations is also renewed on an annual accordance with the provisions set forth above in § 3.5(A)(2)(e) of this Part.

f. Summary. The table below summarizes the areas where distinctions across eligibility pathways for adults 65 and over and those areas where variations occur:

Variations in LTSS Eligibility Pathways for Elders

Eligibility Pathway	Eligibility Criteria Income Limits	Special Conditions
IHCC Group for Elders and Adults with Disabilities (EAD)	100% FPL	If currently receiving preventive level services referred directly for clinical eligibility reassessment

Variations in LTSS Eligibility Pathways for Elders		
Eligibility Pathway	Eligibility Criteria Income Limits	Special Conditions
Special Income	100% FPL up to 300% SSI standard	IHCC group medically needy pathway and for other persons with countable income above 100% FPL
1915 Lookalikes	100% FPL up to 300% SSI standard	1915 Lookalikes is reserved for persons seeking HCBS
Medically Needy	Above 300% of SSI standard	Income cannot exceed average cost of care, as indicated in Section 1502.

4. Children up to Age 19 – Children requiring LTSS are generally evaluated for MACC group eligibility and provided the services and supports they need under the authorities included in the Medicaid State Plan without requiring a separate determination of eligibility. As indicated in Part 2 of this Chapter, there is also a separate eligibility pathway known as Katie Beckett (KB) eligibility, which is named after the young woman who inspired its creation by Congress. The KB pathway is for children with severe chronic diseases and/or disabling impairments who need the scope of services typically provided in a health care institution, but are being cared for at home. The eligibility pathways differ as follows:

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

      (1) MACC group for children: Family income limit – 261% FPL; no resource limit.

      (2) Katie Beckett: Child income limit – Special income limit for LTSS – federal benefit rate; resource limit – $2,000; no income or resource deeming.

   b. Special Conditions. There are several special conditions that apply only to the KB eligibility pathway:

      (1) MACC Group for Children: None

(2) KB: Child must have a disabling impairment and needs requiring the level of care typically provided in a health institution (NF, ICF-ID, H) and live at home. A cost-effectiveness test applies; that is, the cost of care at home must be at or below cost of care provided in a health care institution.

c. Determination Process. The eligibility system considers all children seeking Medicaid eligibility in the MACC group for children first, in accordance with the income limits set in the Medicaid Code of Administrative Rules "Eligibility Requirements" (Section 1305) and the MAGI eligibility process in the Medicaid Code of Administrative Rules "Determination of Income Eligibility" (Section 1307).

(1) If the child is found eligible, a notice is issued and the child is enrolled for services. The online eligibility system proceeds to an evaluation using the KB process if the child is ineligible or a request is made for retroactive coverage or specifically for LTSS. The applicant is then evaluated using the SSI method in Part 3 Chapter 40 of this Title, but using only the income and resources of the child. No deeming applies and the financial eligibility review ends at this point. The next step in the KB eligibility sequence is a determination of disability and level of care review. The final review for KB eligibility is a determination of KB cost-effectiveness.

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

e. Continuing Eligibility. KB clinical eligibility must be reassessed annually. Federal regulations provide an exemption from annual financial eligibility reviews at the point of renewal. A passive renewal process is used for MACC group children as specified in the Medicaid Code of Administrative Rules "Renewal" (Section 1306).

f. Summary. The table below summarizes the variations across eligibility pathways:

Variations in LTSS Eligibility Pathways for Children						
Eligibility Pathway	Eligibility Criteria		Special Conditions	Determination Process	Retroactive Coverage?	Continuing Eligibility
	Income Limits	Resource Limits				
MACC Group for Children	261% FPL	None	None	MAGI-standard based on family income	NO	Passive Renewal
Katie Beckett	FBR	$2,000	Income and resources of parents deemed unavailable to the child; Child must live at home, but institutional level of care needs; cost-effective test required	SSI – method based on child's income and resources only disability determination and level of care assessment required	YES	Modified Active Renewal

3.6 Roles and Responsibilities

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

1. Agency responsibilities – The EOHHS is responsible for determining Medicaid LTSS eligibility, authorizing services, the appropriate level of care planning and service coordination, as dictated by setting, and enrollment in service delivery option of choice.

2. Applicant Responsibilities. Beneficiaries determined eligible through this pathway must provide accurate and timely information and the consent necessary to obtain the health care information required for the clinical eligibility determination.