Memo

TO: State Executives & Affiliate Partners

FROM: Grant Beebe

DATE: 24 OCTOBER 2024

SUBJECT: The Advanced Payment Advantage

Thank you for attending our webinar comparing advanced payment strategies and presumptive eligibility. Delays in processing Long-Term Care Medicaid applications have burdened providers. Presumptive Eligibility requires the State Medicaid Agency to designate a Qualified Entity, posing risks for long-term and post-acute care providers. This memo summarizes the advantages of advanced payment strategies.

Presumptive Eligibility Process Overview

Presumptive Eligibility (PE) enables individuals to access Medicaid-covered services while completing the application process. Nine states use PE for Home- and Community-Based Services (HCBS) programs under non-MAGI Medicaid programs, with coverage lasting sixty days while the complete eligibility determination process is ongoing. Additionally, children covered by CHIP, pregnant women, and persons living with ESRD have presumptive pathways for acute and outpatient care. While states may elect to establish presumptive eligibility pathways for additional eligibility categories, including long-term care residents, through Managed Long-Term Services and Supports or waiver authority*, significant operational, financial, and regulatory risks bear consideration.

LTPAC Context: Operational, Financial, & Regulatory Risks

CMS-approved PE pathways require the State Medicaid Agency to appoint a Qualified Entity to perform the initial financial and functional eligibility screenings necessary to determine whether an individual is eligible for coverage; these entities are generally acute care hospitals, Federally Qualified Health Centers, school-based Medicaid providers, or the like.

> ***Operational Risks***: Qualified Entities must comply with the State's Medicaid Eligibility Policy, HIPAA, HITECH Act privacy best practices, and Fair Credit Reporting Act standards. Acute care hospitals or health systems serving as Qualified Entities may make determinations in their interest, disregarding the downstream impact on long-term care providers due to information asymmetries. Additionally, PE strategies do not address requirements such as the 30-day waiting period for long-term care Medicaid eligibility or the Pre-Admission Screening and Resident Review completion.

Financial Implications: If eligibility is later denied, providers may be expected to repay Medicaid reimbursements while facing regulatory challenges for facility-initiated discharges. Acute care hospitals receive disproportionate share payments and recognize charity care expenses, while long-term care providers cannot.

Regulatory Risks: Facility-initiated discharges are monitored by consumer advocacy organizations, ombudspersons, and licensing agencies. AHCA analysis of standard and complaint survey citations shows nearly 16,000 citations of F-Tags concerning discharge policy and procedures between 2017 and September 2024. PE is not aligned with residency within a provider environment.

Advanced Payment Advantages

Advanced payment strategies, like those used in Rhode Island, offer a cleaner, solutions-oriented path. By requesting advanced payments when Medicaid applications are not processed within the Federal 90-day timeline, providers get compensation for care delivered during the backlog. Because advanced payments are funded through state-share dollars without federal financial participation, State Medicaid Agencies are incentivized to act quickly to avoid further costs. Documentation of this policy alternative is attached, and we would be pleased to provide technical assistance to aid in operationalization.

Additional Solutions

Functional partnerships between individual facilities and their local Medicaid Eligibility Staff are crucial. Inviting Medicaid Staff to your facility promotes collaboration. Facility leadership should visit local Medicaid offices as if they were a referral source. Federal provisions for provider-related donations (42 CFR § 433.66) support the State Medicaid Agency in recruiting and retaining Eligibility staff for community-facing outstation positions. Multiple states and provider members have successfully made use of provider donation flexibilities to support the placement of targeted long-term application support staff in facility-facing positions within their communities.

Please consider how we may offer technical assistance through convening ongoing peer-led discussions or otherwise. Thank you for your interest in discussing the operational, financial, and regulatory risks inherent to PE and the strategic advantages of advanced payment strategy!

Attachment: Rhode Island Policy Demonstration

210-RICR-50-00-4

TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 50 - MEDICAID LONG-TERM SERVICES AND SUPPORTS

SUBCHAPTER 00 - LONG-TERM SERVICES

PART 4 - Long-Term Services and Supports Application and Renewal Process

4.1 Overview

The purpose of this regulation is to set forth the Long-Term Services and Supports (LTSS) application review and renewal process in accordance with current State and federal laws and regulations.

4.2 Legal Authority

A. Title XIX of the U.S. Social Security Act provides the legal authority for the RI Medicaid program. Additionally, legal authority related to long-term services and supports is derived from the following sources:

1. State Law: R.I. Gen. Laws § 40-8-6.1

2. Federal Law: 42 U.S.C. § 1396a; 42 U.S.C. § 1396k; Section 1413(b)(1)(A) of the Affordable Care Act

3. Federal Regulations: 42 C.F.R. §§ 435.905 THROUGH 910; 42 C.F.R. § 435.912(c) (timelines).

4.3 Definitions

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

1. "ACA adults" means persons between the ages of 19 and 64 who are eligible for Medicaid authorized by the federal Affordable Care Act (ACA) of 2010.

2. "Additional documentation request" or "ADR" means the notice sent to applicants subsequent to an initial review of the application's completeness that identifies any additional information/forms that must be submitted, and any related deadlines, for a determination of eligibility to proceed.

3. "Application completeness" means the point in time when all information requested by the State, including the application and any ancillary

required forms and authorizations necessary to determine eligibility, are date-stamped as received by the State.

4. “Application timeliness” means the specific time frame for making determinations of Medicaid eligibility as set forth in federal and State law, regulations and rules. The timelines vary in length depending on whether a functional/clinical eligibility determination is required.

5. “Clinical or functional eligibility” means the application of needs-based criteria to determine whether a person requires the level of care typically provided in an LTSS health institution as defined herein.

6. "Department of Human Services" or "DHS" means the State agency established under the provisions of R.I. Gen. Laws Chapter 40-1 that has been delegated the responsibility through an interagency service agreement with the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, to determine Medicaid eligibility in accordance with applicable State and federal laws, rules and regulations.

7. "DHS-2 application form" means the principal paper application form for Medicaid LTSS.

8. "Eligibility pathway" means one of the various ways authorized under the State’s Medicaid State Plan and/or Section 1115 demonstration waiver that a person may be found eligible for LTSS.

9. "Executive Office of Health and Human Services" or "EOHHS" means the State agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 which is designated as the “single State agency,” authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

10. "Financial eligibility" means the process for determining whether an applicant meets the income and resources requirements for Medicaid eligibility.

11. "Home and community-based services" or "HCBS" means the services and supports provided to Medicaid LTSS beneficiaries at home or in a community-based setting who would require the level of care associated with one of the three institutions (health care facilities identified below) recognized in federal Medicaid law if they were not receiving these services and supports.

12. "Institution" means one of the long-term care institutions recognized in federal Medicaid law and is a State-licensed health care facility where health and/or social services are delivered on an inpatient basis. For the

purposes of this document, the term means long-term care hospitals and treatment facilities (LTHR), intermediate care facilities for persons with intellectual disabilities (ICF/ID), and nursing facilities (NF).

13. "Integrated eligibility system" or "IES" means the State's health and human services computer eligibility system – known as RI Bridges – which processes applications for Medicaid as well as for the programs and services administered by the DHS.

14. "Long-term services and supports" or "LTSS" means a spectrum of services covered by the Medicaid program for people with functional impairments and/or chronic illness that provide assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping).

15. "LTSS specialist" means a State agency representative responsible for determining eligibility for long-term services and supports, authorizing services, and/or providing assistance to people in navigating the Medicaid health care system.

16. "Needs-based criteria" means the basis for determinations of functional/ clinical eligibility for Medicaid LTSS including medical, social, functional and behavioral factors, and the availability of family support and financial resources.

17. "Supplemental forms" means the additional forms all LTSS applicants are required to complete.

18. "Types of LTSS" means the two forms of LTSS authorized under federal law and the State's Medicaid State Plan and Section 1115 waiver: Medicaid LTSS in health care institutions (NFs, ICF/IDs, and LTHR) and Medicaid home and community-based LTSS.

4.4 Summary of LTSS Eligibility Determination Process

A. Eligibility Factors. Evaluations of all applications for Medicaid LTSS are based on eligibility requirements or factors that fall into the following three categories:

1. General Eligibility Factors – Residency, citizenship and immigration status, third-party health coverage, age, health coverage, marital status, dependents (§ 40-05-1.9 of this Title).

2. Financial Eligibility Factors – Varies by eligibility pathway and the method for determining income eligibility in accordance with Part 40-00-3 of this Title.

3. Clinical/functional Eligibility – An applicant's health care and functional health care needs are evaluated based on information obtained from providers using pre-set needs-based criteria. The needs-based criteria for the NF, ICF-ID, and LTHR vary in accordance with the needs of the population served. Separate criteria related to disability status and LOC are also used for children seeking Katie Beckett eligibility. (Subchapter 10 Part 3 of this Chapter).

B. Planning and the Cost of Care. LTSS applicants/beneficiaries are also in engaged in several on-going and post-eligibility processes that ensure they participate in decisions about their care, and that necessary and appropriate services are authorized. Calculation of their liability to pay a share of the cost of LTSS care includes the spouse's and/or dependents' needs and other allowable expenses.

1. Person-centered Planning (PCP) – The person-centered planning process begins when an applicant decides to apply for Medicaid LTSS and continues throughout the eligibility determination process. The applicant/beneficiary and their health care preferences and goals drive the development of the plan (42 C.F.R. § 441, Subpart M).

2. Service Plan and Authorization – The service plan identifies the scope, amount and duration of services necessary to meet the new beneficiary's needs as articulated in the PCP process and other assessments; authorization allows payments to be made for these services.

3. Post-eligibility Treatment of Income (PETI) -- This is the process in which the State determines how much money a beneficiary must pay each month toward the cost of care. Income is calculated and deductions are then taken (also known as "allowances") to cover personal needs and non-Medicaid covered or incurred and unpaid health care expenses. The spousal impoverishment requirements in federal law are also applied, if appropriate, to exclude any of the beneficiary's income that must be set aside to provide financial support for a spouse and/or dependents in the community. (Part 8 of this Subchapter; 42 C.F.R. §§ 435.217; 435.726; 435.236).

4.5 Starting the Application Process

A. Applying for LTSS. All persons seeking initial Medicaid LTSS must apply, including existing Medicaid beneficiaries who are already covered through a non-LTSS pathway for parents/caretakers and adults eligible under the federal Affordable Care Act (ACA) expansion. Persons eligible for Community Medicaid (non-LTSS) are evaluated on a set of general, financial and functional/ clinical eligibility requirements in accordance with § 40-05-1.5.2 of this Title and Rhode Island's Medicaid Section 1115 waiver. The information existing beneficiaries must provide when applying for LTSS is limited to only those eligibility factors

related to clinical / functional and financial eligibility not already known to the agency.

B. Application Points. The State is committed to pursuing a "No Wrong Door" policy that offers consumers multiple application and renewal access points which all lead to the State's IES. (§ 40-00-2.2 of this Title).

1. On-line, Self-Service – Persons seeking initial or continuing eligibility have the option of accessing the eligibility system on-line using a consumer self-service portal through links on the EOHHS (www.eohhs.ri.gov) and DHS (www.dhs.ri.gov) websites or directly through HSRI (HealthSourceRI.com). Supplemental forms and required documentation may be uploaded directly on-line or faxed, emailed or U.S. mailed. The information applicants provide on-line is entered directly into the IES and processed electronically in real-time. The initial steps for applying on-line are as follows:

a. Account Creation. To initiate the application process, a person must create an account in the eligibility system. This can be done through the self-service portal by the applicant or with the help of an eligibility specialist or certified assister.

(1) Identity proofing. The applicant must provide personally identifiable information when creating an on-line account as a form of identify proofing. Verification of this information is automated.

b. Account matches. Once identity is verified, account matches are conducted to determine whether the applicant or members of the applicant's household have other accounts or are currently receiving benefits. The IES draws on information in an applicant's account when determining eligibility for other programs. This reduces the need for additional verification and supportive documentation in some circumstances.

2. Paper DHS-2 Applications – Paper forms may be completed on-site with assistance from LTSS eligibility specialists and/or submitted at various agencies, as indicated in § 4.5(D) of this Part below. Applications may also be mailed or faxed to the address identified on the DHS-2. Irrespective of point of receipt, all applications and supplemental forms are indexed scanned into the IES through the EOHHS central mail management system and assigned for review according to the type of assistance requested.

C. Application Packet. The application packet contains the several forms requesting the information necessary to determine whether a person is eligible for Medicaid

LTSS. There are two types of forms required for Medicaid LTSS eligibility, however applying:

1. General Application Form – The DHS' "Application of Assistance", known as the "DHS-2", is the principal application form a person must complete when applying for Medicaid LTSS. The paper version of the DHS-2 is available on-line at: at one of the DHS offices listed here. Community agencies and LTSS providers may also be able to provide copies of the DHS-2. The DHS-2 is used for LTSS and as the basis for determining eligibility for: Supplemental Nutrition Assistance Program (SNAP), Child Care Assistance Program (CCAP), Community Medicaid for elders and adults with disabilities (EAD) who are seeking long-term care, the Sherlock Plan for persons with disabilities who work (SP), the State-funded optional supplemental security program (SSP) and the RI Works Program.

2. Supplemental Forms – All applicants for LTSS must also complete additional forms that provide the information necessary to review the application and/or determine various eligibility factors.

LTSS Required Supplemental Forms			
Name of Form	**Used in:**	**Details**	**Applicant sends to:**
DHS-2 Cover Sheet	Application	Identifies LTSS applicants and type of services requesting	Agency with DHS-2
CP-12 Applicant Choice	General Eligibility	Applicant must attest that information about types of LTSS (institutional and HCBS) has been provided	Agency with DHS-2
Clinical/functional evaluation by Health Care Provider, GW OMR PM 1 and supporting documentation	Clinical/functional eligibility	Form for health care provider to complete	Principal Health Care Provider (physician, NF, assisted living residence). Agency sends upon request and follows-up if no response by time of application review.

LTSS Required Supplemental Forms			
Name of Form	**Used in:**	**Details**	**Applicant sends to:**
Consent Form, DHS-25M-CL Provider	Clinical/functional eligibility	Supplemental form for health provider which authorizes release of health care information. Two copies included in the application packet to be sent to health care provider and/or community agency Provider	Health Care Provider
Authorization to Obtain or Release Confidential Information, DHS-25 (New consolidated form that incorporates DHS-91)	General/financial eligibility	Release for non-medical confidential information	Agency with DHS-2

3. Limits on Application Information – As the DHS-2 is an integrated application that is used across health and human services programs, applicants must answer questions that are sorted by program. Applicants are responsible for answering only those questions pertaining to eligibility for the programs for which they are applying:

   a. On the paper application, the relevant questions are marked with the acronym associated with the specific programs for which the applicant is applying. “KB” means Katie Beckett, “LTSS” means long-term services and supports

   b. Applicants using the electronic version of the DHS-2 may identify the programs for which they are applying upfront. The IES then automatically sorts the questions they must answer by their program(s) of choice.

D. Application Assistance. DHS and EOHHS eligibility specialists provide application assistance in completing all necessary forms, obtaining and submitting required documentation, and responding to inquiries or requests for information. Assistance is also available through:

1. The Division of Developmental Disabilities in the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) for adults with developmental/intellectual disabilities seeking Medicaid. The division also provides specialized assistance and case management services to beneficiaries.

2. The Division of Elderly Affairs (DEA) of the DHS is an additional source of application services for persons seeking LTSS in the home and community-based setting. These services are provided through community agencies under contract with DEA which also provide needs assessments to applicants and case management services to beneficiaries.

3. Community-based certified assisters including State Health Insurance Assistance Program (SHIP) counselors working through local Senior Centers and THE POINT, the State's Aging and Disabled Resource Center (ADRC).

E. Applicant Rights. The State is responsible for upholding the following rights of Medicaid LTSS applicants:

1. Authorized Representatives – Applicants may designate someone to serve as an authorized representative to help or act on their behalf in dealing with agency eligibility and LTSS specialists.

2. Translation Services – An interpreter or translator is available to assist in the application process, upon request.

3. Protection of Privacy -- All information applicants provide is kept confidential unless the agency is otherwise authorized to share with other State and federal agencies for the purposes of verification and enrollment.

4. Appeals - The agency accepts appeals and holds hearings on actions related to eligibility decisions in accordance with Part 10-05-2 of this Title.

5. Non-discrimination – Applicants are treated in a manner that is free from discrimination based on race, color, national origin, sex, gender identity or sexual orientation, age or disability.

6. Non-LTSS Medicaid Beneficiaries – Existing Medicaid beneficiaries who are seeking to expand their coverage to include LTSS may initiate the application process by requesting a change in coverage through their on-line account or by contacting DHS eligibility specialists.

4.6 Submitting the Application

A. Completion of Forms and Signature. All application forms must be complete and signed before being submitted. To ensure equity between people who apply on-

line versus through the DHS-2, an application that is not completed and signed will not be accepted and will be returned. The IES accepts electronic signatures.

B. Valid Information. Information provided on the application must be validated in accordance with one or more of the following methods to determine eligibility:

1. Attestation – Applicants must attest to the truthfulness and accuracy of the information they provide by signing, under penalty of perjury, the paper application and supplemental forms in ink, or if applying on-line, through an electronic signature. An applicant's responses on the signed application (so-called "attestations") are accepted as valid without further verification or proof for a limited range of eligibility factors, such as State residency and marital status or relationship.

2. Electronic Data Matches – Applicant attestations related to income, immigration status, Medicare coverage, private health insurance, and several other eligibility factors are verified automatically through the IES using electronic matches with various federal and State data sources. Applicants are asked to provide their consent for these electronic data matches on the paper and on-line forms. If these matches fail to validate applicant attestations, the applicant will receive a written request for additional clarifying or supporting documentation before action is taken on eligibility through an ADR.

3. Supporting Paper Documentation/Proof – In instances in which eligibility factors cannot be electronically verified due to a lack of data sources or an information discrepancy, an applicant must submit additional documentation to prove the truthfulness and accuracy of attestations or the full scope of information necessary to evaluate an eligibility factor. The application forms for LTSS identify eligibility factors that require paper documentation.

C. Privacy of Application Information – Application information must only be used to determine eligibility and the types of coverage a person is qualified to receive. Accordingly, the EOHHS, the agencies under its umbrella, and all other entities serving as its agents in the Medicaid eligibility process maintain the privacy and confidentiality of all application information in the manner required by applicable federal and State laws and regulations.

4.7 Application Cycle

A. Application Receipt and Filing date. The date a signed and completed application form is manually or electronically date-stamped as received by the agency is the application filing date. The application filing date is used to determine the eligibility date for LTSS coverage. The eligibility date is the first day of the month in which an application is filed. Retroactive coverage is available if a person would have qualified for LTSS Medicaid for up to three (3) months prior to the

eligibility date. A signed, completed application form is submitted by any of the following means:

1. Electronically through the self-service portal;

2. A paper copy is date-stamped as received by State agency staff;

3. Electronically dated if uploaded, e-mailed, faxed, or scanned;

4. Delivered in-person and date-stamped by State agency staff.

B. Application Data Entry and Tracking. Once an application has been filed, the State agency is responsible for ensuring all required information is scanned or entered into the IES and updated and tracked until eligibility is determined.

C. Application Review Timeline. Under federal regulations, LTSS eligibility determinations are considered untimely if they are not made within the ninety (90) day timeframe beginning on the filing date provided all required sections of the application form(s) have been completed and signed, as appropriate, and submitted by that date, along with any documentation necessary to determine an applicant's identity.

1. In accordance with 42 C.F.R. § 435.912, the State may not be able to determine eligibility within this timeframe in unusual circumstances, such as when the agency cannot reach a decision because: the applicant or health care provider delays or fails to take a required action, or there is an administrative or other emergency beyond the agency's control.

2. An application is considered incomplete until all the information required to determine eligibility has been date-stamped as received by the State. Additionally, State-only interim payments may be available in instances in which the State has not made a determination of eligibility on a complete application, as defined in § 4.8 of this Part.

D. Application Open and Duty to Report Changes. An application must be open for the State to determine eligibility. An application remains open for 180 days from the date the application form is filed, including any reinstatement review period, as set forth in subpart § 4.9(B)(5) of this Part. Applications will be automatically withdrawn and closed at the end of the open period unless the State is responsible for delays in processing materials related to LTSS eligibility factors. Applicants must inform the agency of any changes in an eligibility factor, such as income, resources, health status, within ten (10) days of the date the change occurred during the 180-day period in which the application remains active. General information related to address, authorized representative, immigration status and the like must be updated/corrected as well as the following:

1. Functional/clinical eligibility factors -- In accordance with standing EOHHS rule pertaining to LTSS needs-based determinations, Part 5 of this

Subchapter information related to health and functional status must be no more than (ninety) 90 days old in order to make a fair and accurate assessment of functional/clinical eligibility. Therefore, the must be provided with any information from a health care provider that may in anyway be related to an applicant's level of care needs within the ten-day reporting period.

2. Financial eligibility factors – Application information that is not verified by an electronic data source must be updated/corrected during the period in which an application is open within the required ten-days. This includes, but is not limited to, any information related to changes in income provided from outside the State, resources, home maintenance needs, and health care costs and expenses.

4.8 Application Completeness and Eligibility Determination Timelines

A. Complete Application. Under State law, an LTSS application is considered complete when the application form and "attachments and supplemental information as necessary" provide the agency with sufficient information to determine eligibility.

B. Scope of Information Required. The information required for an application to be considered complete is not fixed. An applicant's unique circumstances dictate which factors must be considered when determining eligibility and, as such, when there is sufficient information to determine eligibility. By signing the application, the applicant self-attests to the truth of the information he or she provides on any required forms submitted to the agency. To the full extent feasible, this information is verified through electronic data sources. However, when no electronic sources are available, the applicant must provide various types of documentation as proof to support self-attestations.

C. The full range of information that may be required for an application to be complete varies depending on the applicant's situation and the type of verification/proof required. A list of eligibility factors and types of acceptable documentation are located on the EOHHS website at: http://www.eohhs.ri.gov/ProvidersPartners/FormsApplications.aspx and is also available on paper by contacting the DHS-LTSS coverage line at (401) 415-8455.

4.9 Information Tracking and Pre-Eligibility Screening and Review

A. Application Information Tracking. Once the application filing date is established, all information submitted to the agency is entered or scanned into the applicant's account in the lES and tracked going forward. LTSS eligibility specialists may provide information, upon request, of the status of any application materials the agency receives after the filing date.

B. Review of application completeness. Within thirty-five days (35) after the application filing date, a review is conducted of any pending application. The purpose of this process is to identify any outstanding information and/or additional supporting documentation or proof that is necessary to determine eligibility. Based on this screening and review:

1. Additional Documentation Request (ADR) – The IES generates a written notice informing the applicant of any outstanding/additional information necessary to complete the application.

2. ADR Response –Applicants must respond to the ADR within fifteen (15) days (ten days (10) from date of the notice plus five (5) days to cover mailing time). Information may be emailed, faxed, mailed, uploaded into the applicant's account or delivered in-person. At any time before the ADR response is due, an applicant may make contact the DHS office, at number indicated on the form, and request for a good cause extension. Such extensions are granted for an additional fifteen (15) days when the applicant provides proof that the inability to respond was due to returned mail, a debilitating health care condition or emergency situation, or the negligence or failure of a third-party.

3. Application Complete – If all requested information is received and the application is considered complete, the process for determining eligibility proceeds. While conducting the eligibility determination, an LTSS eligibility specialist may find that further information is required from the applicant and/or a current or prospective provider to establish a plan of care and/or authorize services. A supplemental ADR may be sent out at this juncture with an appropriate response time

4. Application Denial – If the information requested in an ADR is not received when due, the process for denying the application for non-cooperation is initiated. The applicant has the right to appeal the denial in accordance with the provisions of Part 10-05-2 of this Title.

5. Application reinstatement – An application denied on the basis of non-cooperation under this subpart may be reinstated if the information requested by the applicant is provided to the State within no more than thirty (30) days from the date the denial takes effect if there is time remaining in the ninety (90) day application review period. In such circumstances, a new application review period begins on the application reinstatement date and eligibility dates back to the original application filing date, providing all information subject to change has been updated. If the initial ninety (90) day application review period has expired, the reinstatement date is treated as a new application filing date and the start date of eligibility is determined accordingly.

4.10 Applicant and Agency Responsibilities

A. Applicant responsibilities include:

1. Full responses -- Responding to all questions related to LTSS eligibility on the application and any required supplemental forms;

2. Providing any documentation requested to verify the information on the form at the time the application is submitted and at any point in which change reporting is due;

3. Promptly sending to health care providers the signed clinical evaluation forms and associated releases and ensuring these forms are returned in a timely manner.

4. Clinical status --Reporting any changes in health status, such as trauma or marked decline in functional ability, financial circumstances, such as sale of a home, asset loss or windfall, and/or household composition, such as death or divorce of a spouse, that may affect the determination of level of need after the initial application is submitted during the time the application is pending action by the State.

5. Signature and truthfulness -- Signing the form to provide consent for the determination of eligibility and the verification of information through electronic sources and to attest to the truthfulness of application responses. In the event of a death, the form may be signed by an authorized representative or next of kin.

6. Duty to Report -- Applicants must report changes in any information included on the application and supplemental forms within ten (10) days from the date the change takes effect while the application is open. Self-reports are permitted through the eligibility system consumer self-service portal as well as in person, via fax, or mail. Failure to report in a timely manner may result in the denial of an application based on non-cooperation.

7. Documentation/proof -- Applicants must provide any documentation or proof that otherwise cannot be obtained related to any eligibility factors subject to change upon written request. The information must be provided within the time frame specified in the notice stating the basis for making the agency's request. Failure to respond in a timely manner and/or to provide the information requested without good cause is considered to be non-cooperation and is grounds for denial.

8. Financial resources -- Applicants must, as a condition of eligibility, take any necessary steps to obtain annuities, pensions, retirement and disability benefits along with any other forms of assistance available for

support and maintenance that may be identified by the agency, in writing, in accordance with § 40-00-2.5 of this Title. Good cause exceptions are considered when requested in writing.

B. State Agency responsibilities include:

1. Assistance -- Applicants who are incapacitated or are otherwise unable to fulfill these responsibilities on their own or with the assistance of an authorized representative may request additional assistance from an LTSS eligibility specialist. The EOHHS reserves the discretion to authorize such assistance the Secretary or his or her designee deems appropriate.

2. Voluntary Withdrawal – An applicant may request that an application for Medicaid benefits be withdrawn at any time either through their secure on-line account or by submitting the request in writing via the U.S. Mail or fax to the EOHHS or DHS agency representative. The Medicaid agency sends a notice to the applicant verifying the time and date of the voluntary withdrawal and indicating that the applicant may re-apply at any time.

3. Privacy of Application Information – Application information must only be used to determine eligibility and the types of benefits a person is qualified to receive. Accordingly, the EOHHS, the agencies under its umbrella, and all other entities serving as its agents in the Medicaid eligibility process maintain the privacy and confidentiality of all application information and in the manner required by applicable federal and State laws and regulations.

4. Application Timeliness -An applicant may appeal and request a hearing on the basis of the timeliness if the State fails to provide notification of outstanding documentation and make a determination of eligibility on an application within the ninety (90) day review period.

5. State Payments - In accordance with R.I. Gen. Laws § 40-8-6.1, an LTSS provider may request State-only payment for LTSS if a determination of eligibility on a completed application, as defined herein, has been pending for more than ninety (90) days without action taken by the State.

4.11 Renewal of Medicaid LTSS Eligibility

A. LTSS Medicaid financial and general eligibility must be re-evaluated at least once a year. This annual review is now referred to as a renewal. Federal regulations [42 C.F.R. 435.916(b)] require these annual reviews to consider only those eligibility factors that are subject to change and, to the full extent feasible, utilize electronic data sources for verification purposes. Accordingly, LTSS Medicaid renewals require beneficiaries to review information from the IES on key general and financial eligibility factors that has been updated by internal and external data sources, and report any inaccuracies or changes. The requirements for

general and financial eligibility renewals for Medicaid LTSS are conducted in accordance with § 40-00-2.7 of this Title.

B. Clinical and functional eligibility re-evaluations are also required, but may be performed annually or less frequently depending on the expected scope and duration of the need for LTSS. The requirements for clinical and functional eligibility re-evaluations are conducted in accordance with Part 5 of this Subchapter.

210-RICR-50-00-4

TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 50 - MEDICAID LONG-TERM SERVICES AND SUPPORTS

SUBCHAPTER 00 - LONG-TERM SERVICES

PART 4 - MEDICAID LONG-TERM SERVICES AND SUPPORTS APPLICATION AND RENEWAL PROCESS (210-RICR-50-00-4)

Type of Filing: Refile Capabilities

Department of State

01/04/2022	N/A
Regulation Effective Date	Original Signing Date
E-SIGNED by Department of State on 2021-12-15 16:23:05 EST	December 15, 2021
Department of State Initials	Department of State Date