

0300

MEDICAL ASSISTANCE PROGRAM OVERVIEW

0300.05

MEDICAL ASSISTANCE PROGRAM PURPOSE

REV:06/1994

The Rhode Island Medical Assistance (MA) Program is the federal/state program to meet the medical needs of low income persons who are age 65 or over, blind, disabled, or members of families with dependent children, or qualified pregnant women and children.

The Statutory foundations of the Rhode Island MA Program are Title XIX of The Social Security Act and Rhode Island General Laws 40-8.

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PROGRAM ADMINISTRATION

REV:06/1994

The Rhode Island Department of Human Services (DHS) is the agency of state government which administers the Medical Assistance Program.

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CATEGORIES OF MEDICAL ASSISTANCE

REV:06/1994

DHS determines eligibility for and provides Medical Assistance to Rhode Island residents in two categories - Categorically Needy and Medically Needy.

0300.15.05

Categorically Needy

REV:06/1994

The Categorically Needy are those individuals or families eligible for or receiving cash assistance under the SSI or AFDC Programs, or who are deemed eligible, or are legislated under a special provision to be Categorically Needy.

SSI recipients, families eligible for and/or receiving AFDC and children for whom payments are made under Title IV-E are AUTOMATICALLY eligible for MA as Categorically Needy. A separate determination of eligibility for MA is not required for these individuals.

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Medically Needy

REV:06/1994

The Medically Needy are those individuals or families whose resources and/or income exceed the standards required for

Dental Services	Yes	Yes
Clinical Laboratory Services	Yes	Yes
Durable Medical Equipment, Surgical Appliances, and Prosthetic Devices	Yes	Yes 4
Certified Home Health Agency Services	Yes	Yes
Podiatry Services	Yes	No
Ambulance Services	Yes	Yes
Community Mental Health Center Services	Yes	Yes
Substance Abuse Services	Yes 5	Yes 5
Nursing Facility Services	Yes	Yes
Optometric Services	Yes 6	Yes 7
Intermediate Care Facility and Day Treatment Services for the Mentally Retarded	Yes	Yes

NOTE: Inpatient hospital services are subject to admission screening and hospital utilization review procedures. Outpatient hospital services are subject to hospital utilization review procedures.

- 1 The cost of abortion service is paid only when it is necessary to preserve the life of the woman or when the pregnancy is the result of an act of rape or incest.
- 2 Organ transplant operations as described in section 0300.20.05.25 are Medical Assistance services.
- 3 A \$3.00 co-payment is charged to eligible individuals for non-emergency services provided in a hospital emergency room.
- 4 Hearing aids and molded shoes are excluded.
- 5 Limited to counseling and Methadone maintenance services provided by centers licensed and funded by

the Division of Substance Abuse of MHRH.

- 6 For recipients age 21 and older, the following optometry services are limited to once every two years:
one refractive eye care exam; one pair of eyeglasses (frames, lenses, dispensing fees).
- 7 For recipients age 21 and older, payment will be made for one refractive eyecare exam in a two year period. Payment is not made for eyeglasses (frames, lenses, dispensing fees).
- 8 Individuals receiving Medicare Part A, Part B, and/or Part D will receive Pharmacy services through a Medicare Prescription Drug Plan.

0300.20.05.05 Emergency Room Co-Payment Required

REV:06/1994

With certain recipients exempted, a recipient co-payment of \$3.00 will be imposed for a hospital emergency room visit WHEN THE SERVICES PROVIDED DURING THE VISIT DO NOT MEET THE DEFINITION OF EMERGENCY SERVICES. The co-payment is not imposed for children under 18, IV-E and non-IV-E foster care children, adoption assistance children, pregnant women, and institutionalized individuals.

The provider is responsible for collecting the co-payment. The collection of the co-payment is an issue between the recipient and the provider. A provider may not deny service to a recipient who is unable to pay the co-payment at the time the service is delivered. The co-payment will not be imposed on the recipient and deducted from the hospital's claim when a claim is for an emergency service as defined below.

Emergency services are defined as services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Following is a list of examples of presenting problems/diagnoses that will not incur a co-payment:

- o Chest pain
- o Shortness of breath or difficulty breathing
- o The sudden onset of:
 - high fever in children under five years
 - loss of vision, hearing, memory, motion or speech
 - allergic reaction with swollen tongue or fullness of throat
 - paralysis
- o Suspected poisoning
- o Seizures, convulsions or unconsciousness
- o Drug overdose
- o Suicide attempt
- o Psychotic behavior
- o Complications of Pregnancy:
 - sudden vaginal bleeding
 - membrane rupture
 - premature labor
 - suspected miscarriage
- o Severe and unexplained bleeding

At the point of service, the hospital will determine if the visit is subject to a co-payment, and if the recipient is subject to imposition of co-payment. If both conditions are met, the hospital will charge the recipient the \$3.00 co-payment, and issue a form MA-300, which advises the recipient of the co-payment, and his/her rights to appeal (see Section 0110, Complaints and Hearings, of the DHS Policy Manual).

The hospital must bill the Medical Assistance Program with the appropriate ICD-9-CM diagnosis code(s), and a description of emergency services provided. Such services must be documented in the hospital medical record. The co-payment will be deducted from the Medical Assistance allowed payment during claims processing.

0300.20.05.10 **EPSDT**
 REV:10/1994

Title XIX of the Social Security Act provides for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of eligible Medical Assistance recipients under age 21 to ascertain physical and mental defects, and requires treatment to correct or ameliorate defects and medical conditions found. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) further mandates that under EPSDT, services will be provided for such other

necessary health care, diagnostic services treatment, and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services, WHETHER OR NOT SUCH SERVICES ARE NORMALLY COVERED UNDER THE MEDICAL ASSISTANCE SCOPE OF SERVICES. Eligible individuals under age 21 receive Medical Assistance services consistent with EPSDT requirements.

All services formerly provided under the Severely Disabled Children (SDC) Waiver, which was discontinued October 15, 1994, are covered in the same way under the EPSDT program.

The Severely Disabled Children Waiver provided in-home nursing services for medically fragile children. The medically fragile child is one who requires a medical device to replace or to compensate for a vital body function. This includes but is not limited to mechanical ventilation, oxygen supplementation, feeding tubes, cardiorespiratory monitoring, tracheal care and suctioning, and/or I.V./T.P.N.

Children are referred for services from a variety of sources, including pediatricians, hospital discharge staff, VNA's and parents. In order for a child to be determined eligible for in-home services there needs to be skilled nursing needs identified, that is, the child would have to be dependent on a medical device for maintenance of life.

When a child is identified as requiring in-home nursing care, the physician makes a request to DHS/EPSDT and includes a medical history and a description of the child's current status. The request is then reviewed by OMR and EPSDT staff. If the child is an in-patient, DHS staff participate in the discharge planning activities and assist in determining level of in-home services.

This process includes input from the parents, physicians, nursing staff, third party insurers and others as appropriate, e.g., DCYF. If the child is already in the community, OMR staff would meet with the parents, and determine the appropriateness of care in conjunction with the physician and others that may be involved with the child. The cost of in-home services must be less than care in a hospital or pediatric skilled nursing facility.

This process encourages a family centered approach which supports the parents in making decisions for and about the home

care plan for their child. The parents are encouraged to communicate with other families who have experienced home care and to understand their options in making decisions regarding providers of care.

Nursing services are authorized by OMR staff on a monthly basis and are adjusted according to the medical/nursing needs of the child.

0300.20.05.15 Abortions, Rape, or Incest

REV:06/1994

The cost of abortion services is paid when the pregnancy is the result of an act of rape or incest or it is necessary to preserve the life of the woman.

The following policy and procedure is to be followed when the pregnancy is a result of an act of rape or incest which will qualify for reimbursement by the Rhode Island Medical Assistance Program:

- o The patient must provide a signed written statement attesting to the fact that the pregnancy is the result of an act of rape or incest. This requirement shall be waived if the treating physician certifies that in his or her professional opinion, the patient was unable for physical or psychological reasons, to comply with this requirement.

- o The treating physician must provide a signed statement that she/he performed the termination of the pregnancy and that the pregnancy resulted from an act of rape or incest.

- o The statements must be kept in the medical record for a period of three years to maintain an audit trail.

- o The procedure must be performed by a licensed treating physician in a hospital setting or licensed out-patient facility.

0300.20.05.20 Abortions, To Save the Life of the Mother

REV:05/1995

Payment for an abortion will be rendered when a physician has found, and certified in writing to the Department of Human

Services at the time payment for services is requested, that an abortion was medically necessary to save the life of the mother.

To qualify for reimbursement by the Rhode Island Medical Assistance Program for an abortion, the following policy must be followed in order to document medical necessity to save the life of a mother. (See section 0300.20.05.15 relative to payment for an abortion when the pregnancy is the result of an act of rape or incest.)

To receive Medical Assistance payment for services, the physician must:

- o be a doctor of medicine or osteopathy who is licensed to practice in the State of Rhode Island;
- o determine and certify in writing that in his/her professional judgement, the abortion was medically necessary to save the life of the mother;
- o retain a copy of the certification in the patient's medical record for a period of three years for purposes of audit;
- o submit a copy of the certification, which must contain the name and address of the patient, attached to the request for payment for services.

0300.20.05.25 Organ Transplant Operations

REV:05/1995

ORGAN TRANSPLANT OPERATIONS

The following organ transplant operations are provided as Medical Assistance services when medically necessary and when prerequisites are met:

- KIDNEY TRANSPLANTS:
Certification from an appropriate medical specialist as to the need for the transplant.
- LIVER TRANSPLANTS
Certification from an appropriate medical specialist as to the need for the transplant.
- CORNEA TRANSPLANTS
Certification from an appropriate medical specialist

as to the need for the transplant.

- PANCREAS TRANSPLANTS
Certification from an appropriate medical specialist as to the need for the transplant; evaluation at the transplant facility.
- BONE MARROW TRANSPLANTS
Certification from an appropriate medical specialist as to the need for the transplant.
- LUNG TRANSPLANTS
Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.
- HEART TRANSPLANTS
Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.
- HEART/LUNG TRANSPLANTS
Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.
- OTHER ORGAN TRANSPLANT OPERATIONS
Such other organ transplant operations as may be designated by the Director of the Department of Human Services after consultation with medical advisory staff or medical consultants.

Medical Necessity

Medical necessity for an organ transplant operation is determined on a case-by-case basis using the following criteria: medical indications and contra-indications; progressive nature of the disease; existence of alternative therapies; life threatening nature of the disease; general state of health of the patient apart from the particular organ disease; any other relevant facts and circumstances related to the applicant and the particular transplant procedure.

Prior Written Approval

Prior written approval of the Director or his/her designee

is required for all covered organ transplant operations. Procedures for submitting a request for prior approval authorizations are delineated in sections 200-30-1 through 200-30-5 of the Medical Assistance Program Provider Reference Manual.

0300.20.05.30 Transportation Services

REV:12/2001

The Department recognizes that Medical Assistance recipients need available and appropriate transportation in order to access medical care, and assures the provision of such transportation when required to obtain medically necessary services covered by the MA program as follows:

INFORMATION

An informational sheet about MA transportation services for elderly and individuals with disabilities is available at DHS offices or by calling the DHS Information line at 462-5300, for hearing impaired 462-3363.

EMERGENCY TRANSPORTATION

For purposes of this policy section, emergency transportation means transportation to medical treatment when required to obtain emergency health care services for unforeseen circumstances which demand immediate attention at a hospital to prevent serious impairment or loss of life. Medically necessary emergency transportation is provided by ambulance.

When medical services are obtained at a hospital participating in the MA program, appropriate transportation home, if needed, is arranged by the hospital social service or emergency department staff.

NON EMERGENCY TRANSPORTATION

Generally, non-emergency transportation means transportation needed to travel to or from necessary routine, planned medical treatment covered under the MA scope of services at a MA participating provider.

The use of friends, neighbors, and family members to provide non-emergency transportation is encouraged. In addition, free transportation, which may be available from health centers, community agencies or volunteer groups should be utilized

whenever possible. Medically necessary transportation to or from medical treatment is also available as follows:

- o RIDE PROGRAM

RIDE provides door-to-door transportation to individuals over age sixty (60) and individuals with disabilities of all ages who meet certain criteria. Transportation is generally available weekdays for doctor's appointments, therapy, adult day care, medical tests and other medical treatment. Transportation may be requested by calling RIDE at 461-9760 or 1-800-479-6902 at least two (2) weeks prior to the medical appointment.

- o Rhode Island Public Transit Authority (RIPTA)

Individuals who receive MA based on age (65 or older) or disability may apply for the "no fare" program and ride free with a RIPTA Senior/Disabled ID card during all hours of operation on regularly scheduled routes.

The Senior/Disabled ID may also be used to obtain RIPTA flex service, designed to reach areas where fixed bus routes do not go. Flex service is currently available by reservation or at designated regular bus stops from Monday through Friday, 6:00 AM to 6:30 PM in only a few areas of the State.

Information about flex service may be obtained by calling RIPTA at 1-877-906-FLEX (3539).

Applications for the Senior/Disabled "no fare" program are available at the RIPTA Identification Office, 218 Weybosset Street, Providence, RI or through the RIPTA Road Trip Community Outreach Program. Applicants must provide a copy of their RI Pharmaceutical Assistance for the Elderly (RIPAE) Card, Medical Assistance ID card, or No Fare Certification Letter from the Department of Elderly Affairs to RIPTA. Information about the Senior/Disabled "No Fare" program may be obtained by calling 784-9500.

RIPTA bus passes are also made available to Rite Care and Rite Share program participants in accordance with provisions contained in Section 0348.45.05 of the DHS Manual.

RIPTA also offers modified curb to curb Paratransit Service that is comparable to existing RIPTA bus routes for

individuals with disabilities who are unable to use regular bus service. Additional information and eligibility applications are available from the RIPTA Paratransit Division Coordinator at 784-9500, ext 153, or for hearing impaired 784-3524.

From time to time, transportation services offered by RIPTA may change as new or pilot programs are developed.

When none of the above options are available or appropriate, assistance with non-emergency transportation may be obtained by calling DHS at 784-3899 during normal business hours - Monday through Friday, 8:30am to 4:00pm. The recipient is not required to provide verification of the unavailability of alternative or free transportation. All vendors authorized to provide medical transportation must meet the standards established for MA providers by DHS. Prior authorization must be obtained before payment is made for non-emergency transportation to a provider of transportation services.

Transportation is authorized by the most economical means, unless there are compelling medical reasons for using more expensive means. Payment is not authorized for any of the following reasons:

1. For transportation which is ordinarily made available to other persons in the community without charge;
2. For care or services that are not covered under the MA program;
3. To non-participating service providers; or,
4. When the MA recipient is not actually transported in the vehicle.

0300.20.05.35 PHARMACY SERVICES

EFF:01/2006

Under the Medicare Part D Program, in accordance with the Medicare Modernization Act of 2003, Medicaid beneficiaries who also receive Medicare Part A and or Part B, qualify for Part D and must receive their pharmacy services through a Prescription Drug Plan. Therefore, Medicaid beneficiaries who also receive Medicare benefits do not receive pharmacy benefits under the State Medicaid Program. There are, however, five (5) classes of drugs that are exempted from these drug plans and for which Medicaid will provide coverage under Medicaid Pharmacy Services to those receiving Medicare. The five (5) classes of drugs are:

barbiturates, benzodiazepines, vitamins, over the counter medications, and cough and cold medications.

0300.20.05.35.05 PHARMACY SERVICES COST SHARING REQUIREMENTS
EFF:01.2006

Individuals who receive both Medicaid and Medicare benefits may be subject to cost sharing requirements under Medicare Part D in the form of premiums and/or co-payments.

PREMIUMS:

Individuals who select a Part D plan with enhanced benefits will be responsible for that plan's premiums.

CO-Payments:

Individuals will be required to pay a co-payment for each prescription that they purchase.

Income Level	Amount of Co-Payment
Income below 100% FPL	\$1.00 Per Generic Prescription \$3.00 Per Brand Name Prescription
Income above 100% FPL	\$2.00 Per Generic Prescription \$5.00 Per Brand Name Prescription

Individuals who are participants in both waiver and assisted living programs and who receive both Medicaid and Medicare benefits will be required to pay a co-payment for their prescriptions.

EXCEPTION TO CO-PAYMENT REQUIREMENT:

Institutionalized individuals residing in nursing facilities will not be required to pay a co-payment for their prescriptions.

No co-payments are required for those five (5) classes of medications listed in DHS Policy Section 0300.20.05.35 that are not covered by Medicare Part D Prescription Plans.

0300.20.20 **Waiver Programs**

REV:06/1994

Section 1915(c) of the Social Security Act permits states to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. Waiver services are in addition to the services otherwise provided under the Medical Assistance Program.

Waiver services may include case management, personal care, adult day care, homemaker services, respite care and similar home-based services.

The Rhode Island Department of Human Services operates several programs under Home and Community-Based Services Waivers. To be eligible, a recipient must require the level of care provided in an institutional setting, be in one of the target groups of an established waiver program and meet the requirements of the particular waiver program. Waiver recipients must be eligible as Categorically Needy or Medically Needy, as required by the specific waiver program.

0300.20.25 **MA Payment Policy**

REV:03/2002

Medical Assistance is the payor of last resort. Community, public and private resources such as Federal Medicare, Blue Cross/Blue Shield, VA benefits, accident settlements or other health insurance plans must be fully utilized before payment from the Medical Assistance Program can be authorized.

Payments to physicians and other providers of medical services and supplies are made on a fee for service basis in accordance with applicable federal and state rules and regulations, and established rates of reimbursement governing the Rhode Island Medical Assistance Program. Payments to physicians and other providers of medical services and supplies represent full and total payment. No supplementary payments are allowed. Direct reimbursement to recipients is prohibited except in the specific circumstances set forth in Section 0302.30.10 to correct an erroneous denial which is reversed on appeal.

Payments for enrollment in a Rite Care Health Plan or a Rite Share approved employer based group health plan are made in accordance with policy contained in Section 0348.75.15 and 0349.30 respectively.

0300.20.30 **Provider Deficiencies/Plan of Correction**
REV:06/1994

The Rhode Island Department of Health surveys all Nursing Facilities (NF) and Intermediate Care Facilities/Mental Retardation (ICF/MR) for compliance with the federal participation requirements of the Federal Medicare and State Medical Assistance Programs. As a result of these surveys, reports are issued for certification purposes which cite provider deficiencies, if any exist, together with appropriate plans of correction. Subsequent corrections of deficiencies are also reported.

Statements of provider deficiencies must be made available to the public through the Social Security Offices and Public Assistance Agencies.

The Health Standards and Quality Bureau of the Regional Office transmits these reports in the following manner:

- o Nursing Facilities (NF) - Reports are sent to the Social Security Administration (SSA) district office that covers the area in which the facility is located, and the Central Office of the Department of Human Services (DHS).

- o Intermediate Care Facilities/Mental Retardation (ICF/MR) - Reports are sent to the Central Office of DHS.

The agency is required to send the reports for both Nursing and Intermediate Care Facilities/Mental Retardation to the appropriate Long Term Care (LTC) Unit covering the district in which the facility is located. The agency must also send the ICF reports to the SSA office covering the catchment area in which the facility is located.

These files are available to the public upon request. If an individual has questions about the reports, or requests additional data, the Supervisor will be informed and will contact the Chief Medical Care Specialist in the Long Term Care (LTC) Unit at Central Office.

Material from each survey will be held in the District Office for three (3) years and then destroyed.

0300.20.35 Medicare Buy-in

REV:05/1995

Medicare Buy-in is a provision of the Medical Assistance program which allows Medical Assistance to pay for the Medicare Part A and/or Part B premiums of certain categories of MA eligibles.

0300.20.40 Pharmacy Lock-In Program

REV:01/2002

The Code of Federal Regulations at 42CFR440.230(d) allows DHS to place appropriate limits on a medical service based on such criteria as medical necessity or on utilization control procedures. The Medical Assistance Pharmacy Lock-In Program has been established by the Division of Health Care Quality, Financing and Purchasing to restrict recipients whose utilization of Medical Services is documented as being excessive. Recipients are "Locked-In" to specific providers in order to monitor services received and reduce unnecessary or inappropriate utilization. This program is intended to prevent Medical Assistance recipients from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

0300.20.40.05 Enrollment in Pharmacy Lock-In Program

REV:01/2002

Whenever Medical Assistance records indicate that recipient utilization is excessive or inappropriate with reference to medical need, the Division of Health Care Quality, Financing and Purchasing may require an individual to designate a physician and pharmacy of choice for exclusive service in order to:

- o Protect the individual's health and safety;
- o Provide continuity of medical care;
- o Avoid duplication of service by providers;
- o Avoid inappropriate or unnecessary utilization of Medical Assistance as defined by community practices and standards; and,

- o Avoid excessive utilization of prescription medications.

Excessive utilization of prescription medications will be determined from published current medical and pharmacological references.

The Department selects for enrollment in the Medical Assistance Pharmacy Lock-In Program recipients who have a documented history of obtaining excessive or inappropriate prescribed drugs under the Medical Assistance Program.

Recipients will be given a written notice (MA/DUR-1) of his/her excessive or inappropriate utilization thirty days prior to the implementation of the restriction and will be requested to choose a primary pharmacy/physician as a single source of medical care.

The notification will also advise the individual that failure to cooperate in this program will necessitate the Department's designating a physician/pharmacy for the individual based on the recipient's previous use and geographical location.

The notification will include the individual's right to request a fair hearing within 30 days if he/she disagrees with the findings and the Department action.

0300.20.40.10 REVS Identification of Lock-In Recipients
REV:05/1995

Recipients who are in the Medical Assistance Pharmacy Lock-In Program are identified through the Recipient Eligibility Verification System (REVS).

0300.20.40.15 Primary Pharmacy of Choice
REV:05/1995

The Primary Pharmacy of Choice must monitor the drug utilization of each restricted recipient and must exercise sound professional judgement when dispensing drugs in order to prevent inappropriate drug utilization by the recipient. When the pharmacist reasonably believes that the recipient is attempting to obtain excessive drugs through duplicate prescriptions or other inappropriate means, the pharmacist must contact the providing physician to verify the authenticity and accuracy of the prescription presented. Primary pharmacies that are found on review to be dispensing drugs in a manner that is inconsistent with professional standards may be subject to

administrative action by the Department, including the recovery of payments.

0300.20.40.20 Primary Care Physician

REV:05/1995

The Primary Care Physician is delegated the responsibility of overseeing the health care needs of the restricted recipient and providing all medically necessary care for which the recipient is eligible. The provider should be knowledgeable about the recipient's health care problems and aware of the care and services the recipient is receiving.

0300.20.40.25 Change in Primary Pharmacy/Physician

REV:05/1995

A recipient may change his/her primary pharmacy/physician for reasonable cause by notifying the Medical Assistance Pharmacy Lock-In Program and choosing a new primary pharmacy/physician.

0300.20.40.30 Change in Recipient Status

REV:05/1995

If, after review of the recipient's drug-usage profile, it is determined by the Medical Assistance Pharmacy Lock-In Program that restriction is no longer appropriate, the restriction will be removed. Such review will not take place prior to 15 months from the date of enrollment.

0300.25 OVERVIEW OF MA ELIGIBILITY REQUIREMENTS

REV:06/1994

The eligibility requirements of the MA Program are categorized as technical requirements, characteristic requirements, cooperation requirements, cost effectiveness and financial requirements.

0300.25.05 Technical Eligibility Requirements

REV:06/1994

Technical eligibility requirements for the Rhode Island MA Program are citizenship, residence and possession of, or application for, a social security number.

0300.25.10 Characteristic Eligibility Requirements

REV:01/2002

Characteristics are non-financial eligibility factors. The required characteristics for an individual applying for MA are those of the SSI program - age (65 or older), blindness or disability. The required characteristics for families are generally those of the FIP program - age, relationship and deprivation factor (absence, death, unemployment, or incapacity of a parent or caretaker relative).

Pregnant women, certain children and parent(s) (or caretaker relative) of eligible children may be eligible for MA without having one or more of the usual characteristics of the AFDC program prior to 5/97. For example, pregnant women, poverty level children and Section 1931 parents or caretaker relatives are not required to meet a deprivation factor. All children are required to meet an age requirement.

0300.25.15 Cooperation Requirements

REV:06/1994

As a condition of eligibility, the MA applicant/recipient must meet certain cooperation requirements, such as providing the information needed for an eligibility determination, taking reasonable action to make income or resources available for support, assigning of rights to medical support or other third party payments for medical care, or pursuing eligibility for other benefits. Failure to cooperate may result in a denial of eligibility or case closure.

0300.25.20 Financial Eligibility Requirements

REV:06/1994

Financial eligibility is based on the applicant/recipient's income and resources. Certain income and resources are COUNTABLE and thus included in the calculation of the individual's total income and resources to determine if financial eligibility exists. Other income and resources may be EXCLUDED from the calculation and not count toward the individual's allowable limit.

0300.25.20.05 Income Flex-Test and Spenddown

REV:06/1994

Medical Assistance policy provides that an otherwise eligible applicant with income in excess of the allowable income limits may be eligible for MA if the excess income is insufficient to meet the cost of certain medical expenses. An individual's unpaid medical bills and current receipts for incurred medical

expenses may be subject to an Income Flex-Test. The applicant may qualify for an income spenddown in which allowable medical expenses absorb his excess income, enabling him to qualify for MA as Medically Needy.

0300.30

METHODOLOGY FOR DETERMINING COVERAGE GROUP

REV:11/1998

A Coverage Group is a classification of individuals eligible to receive Medical Assistance benefits. There are numerous coverage groups distinguishable by income and resource standards and other non-financial criteria. An individual must satisfy all the requirements of at least one coverage group to be eligible for Medical Assistance.

Medical Assistance coverage groups are categorized as SSI-related, family-related or special treatment coverage groups.

The term "SSI-related" refers to the methodologies used for evaluating the individual's income and resources, and the non-financial criteria to be met for MA eligibility. Thus, an individual may be eligible for one of the SSI-related coverage groups if he/she is blind, disabled or age 65 or over, and has income and resources within the limits required for MA eligibility. Some coverage groups in this category are referred to as "special treatment" coverage groups (e.g., QMBs, SLMBs, QIs, etc.).

Similarly, the term "family-related" refers to the methodologies for evaluating income, resources, and the non-financial criteria to be met for determining eligibility under family MA coverage groups. Thus, if family members meet the required characteristics of MA for families, then the countable income and resources are evaluated using the family-related methodologies.

Pregnant women, certain children and parent(s) of eligible children may qualify for MA without possessing an SSI characteristic or a family characteristic of deprivation through the absence, death, incapacity or unemployment of a parent or caretaker relative. For example, a pregnant woman may be eligible for MA without a deprivation characteristic or a resource test. For families, only Medically Needy eligibility, including Medically Needy eligibility based on spending down excess income, requires a deprivation characteristic.

Early in the application process an initial determination is made regarding the potential coverage group to which the MA applicant may belong, usually based on the non-financial criteria of the coverage groups. MA eligibility is then determined based on the applicable income/resource standards of the individual's particular coverage group.

If an applicant is a potential candidate for more than one coverage group, then the determination of MA eligibility is made considering all possible coverage groups. The agency must allow an individual who would be eligible under more than one category to have his/her eligibility determined for the category he/she selects.

0300.35

ORGANIZATION OF THE MANUAL

REV:01/2002

The Medical Assistance Policy Manual is comprised of four major topics of which COMMON PROVISIONS is the first. The three remaining topics are as follows:

- o Sections 0326 through 0349 of this Manual set forth the policies and procedures which govern Medical Assistance eligibility for families with dependent children, poverty level children, pregnant women, and children in foster care.
- o Sections 0376 through 0398 of the Manual set forth policies and procedures to determine Medical Assistance eligibility for Aged, Blind, or Disabled individuals or couples living in community settings (SSI-Related cases) are set forth in Sections 0350 through 0374.
- o Sections 0376 through 0398 of the Manual set forth policies and procedures to determine Medical Assistance eligibility and Medical Assistance payment for services to institutionalized individuals. Institutionalized persons in this context refers to individuals who reside in institutional settings, or who receive home and community based services under a Waiver.