

0372

SPECIAL TREATMENT COVER GROUPS

0372.05

MEDICARE PREMIUM PAYMENT PROGRAM

REV:02/2013

A. Medicare is the federal health insurance to which individuals who are insured under the Social Security system are entitled once they attain 65 years of age or reach the 25th month of a permanent and total disability. Medicare is also available to individuals who have permanent kidney failure and individuals who received a kidney transplant. Medicare has two parts:

1. Part A Medicare Insurance
 - a. Pays for hospital services and limited Skilled Nursing facility services
 - b. Is available without charge to individuals who are insured under Social Security or Railroad Retirement systems and who have attained 65 years of age or have reached the 25th month of a permanent and total disability
 - c. Is available without charge to certain individuals who receive continuing dialysis for permanent kidney failure and certain individuals who have had a kidney transplant
 - d. Is also available to aged or disabled individuals who are not insured under the Social Security System for a premium amount determined by the Social Security Administration
2. Part B Medicare Insurance
 - a. Pays for physician services, durable medical equipment and other outpatient services
 - b. Is available to both "insured" and "uninsured" individuals who have attained 65 years of age or have reached the 25th month of a permanent and total disability upon payment of a monthly premium.
 - c. The Part B premium as of January 1, 2013 is \$104.90 for timely enrollees.

B. Enrollment

1. Individuals who receive Social Security or Railroad Retirement benefit payments are automatically enrolled in Medicare when they turn 65 or reach their 25th month of disability.
2. Individuals who need to apply for enrollment in Medicare Include those who:
 - a. Have not applied for Social Security or Railroad Retirement Benefits
 - b. Were involved in certain Government employment
 - c. have kidney failure/kidney transplant.
3. The initial enrollment period is a seven-month period that starts three (3) months before the individual first meets the requirements for Medicare. Individuals who do not enroll in the initial enrollment period may enroll in the general enrollment period, held each year from January 1 through March 31.

- C. In accordance with federal law, limited Medical Assistance is provided to low-income Medicare beneficiaries. This limited coverage helps eligible individuals pay for some or all of their out-of-pocket Medicare expenses. There are four (4) categories of Medicare Premium Payment Program Benefits:
1. Qualified Medicare Beneficiary (QMB)
 2. Specified Low Income Medicare Beneficiary (SLMB)
 3. Qualifying Individual-1 (QI-1)
 4. Qualified Disabled Working Individual (QDWI)

0372.05.05 Qualified Medicare Beneficiary (QMB)

REV:02/2013

- A. QMBs were established under the legal authority of the Medicare Catastrophic Coverage Act (MCCA) of 1988. States are required to pay Medicare Part A and Part B premiums, deductibles, and co-payments on behalf of eligible individuals. For eligible QMBs, Medical Assistance makes a direct payment to the federal government for the Part A premium (if any), the Part B premium, and provides payments for Medicare co-insurance and deductibles as long as the total amount paid by the Medicare Program does not exceed the Medical Assistance Program allowed amount(s) for the service(s). An individual may qualify for and receive QMB and full Medical Assistance at the same time.
1. A Qualified Medicare Beneficiary (QMB) is an individual or member of a couple who:
 - a. Is enrolled in or entitled to Medicare Part A;
 - b. Has countable resources of \$7,080 for an individual or \$10,620 for a couple;
 - c. Has countable income less than or equal to one hundred (100%) percent of the Federal Poverty (FPL) Guidelines; and
 - d. Meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medical Assistance Program.
 2. Under this coverage group:
 - a. Individuals cannot be reimbursed directly by Medical Assistance;
 - b. Eligibility begins on the first day of the month after the application is filed and all eligibility requirements are met. There is no provision for retroactive eligibility;
 - c. Eligibility is certified for a twelve (12) month period;
 - d. Countable income is determined using SSI related methodology (DHS Manual Sections 0356 and 0364);
 - e. Income limits are rigid. There is no flexible test of income; and
 - f. Cost-of-living increases in Title II benefits (COLAs), effective in January each year are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty (FPL) Guidelines update is published.

0372.05.10 Specified Low Income Medicare Benef (SLMB)

REV:02/2013

- A. SLMBs were established under the legal authority of the Omnibus Budget Reconciliation Act (OBRA) of 1990. States are required to pay the Medicare Part B premium on behalf of eligible individuals. Medical Assistance makes a direct payment to the federal government for the Medicare Part B premium for an eligible SLMB. An individual may qualify for and receive SLMB and full Medical Assistance at the same time.
1. A Specified Low-Income Medicare Beneficiary (SLMB) is an individual or member of a couple who:
 - a. Is enrolled in or entitled to Medicare Part A;
 - b. Has countable resources of \$7,080 for an individual or \$10,620 for a couple;
 - c. Has countable income in an amount greater than one hundred (100%) percent of the Federal Poverty (FPL) Guidelines and less than or equal to one hundred twenty (120%) percent of FPL; and
 - d. Meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medical Assistance Program.
 2. Under this coverage group:
 - a. Individuals cannot be reimbursed directly by Medical Assistance;
 - b. Eligibility begins on the first day of the month in which the application is filed and all eligibility requirements are met;
 - c. Eligibility is certified for a twelve (12) month period;
 - d. Retroactive eligibility may be determined and benefits granted for the three months prior to the month of application;
 - e. Countable income is determined using SSI-related methodology (DHS Manual Section 0356 and 0364);
 - f. Cost-of-living increases in Title II benefits (COLAs) effective in January each year are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty (FPL) Guidelines update is published; and
 - g. Income limits are rigid. There is no flexible test of income.

0372.05.15 Qualifying Individual-1 (QI-1)

REV:02/2013

- A. Qualifying Individuals were established under the legal authority of the Balanced Budget Act (BBA) of 1997. States are required to help pay certain Medicare costs through a capped allocation of funds for Qualifying Individuals-1 (QI-1). Medical Assistance makes a direct payment to the federal government for the Medicare Part B premium for an eligible QI-1. Qualifying Individuals (QI 1) are not otherwise eligible for Medical Assistance. QI benefits are subject to federal appropriations.
1. A Qualifying Individual-1(QI-1) is an individual who:
 - a. Is enrolled in or entitled to Medicare Part A;
 - b. Has countable income greater than one hundred twenty (120%) percent of the Federal Poverty (FPL) Guidelines and less than one hundred thirty five (135%) of FPL;
 - c. Has countable resources of \$7,080 for an individual or

- \$10,620 for a couple;
 - d. Meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medical Assistance Program; and,
 - e. Is not eligible for Medical Assistance under any other coverage provision.
 - 2. Under this coverage group:
 - a. The individual cannot be reimbursed directly by Medical Assistance;
 - b. Countable income is determined using SSI-related methodology (See DHS Manual Sections 0354 and 0362);
 - c. Cost-of-living increases in Title II benefits (COLAs), effective in January each year, are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty (FPL) Guideline update is published;
 - d. Eligibility begins the month in which the application is filed and all eligibility requirements are met;
 - e. Eligibility may be established and benefits granted up to three months prior to application, but not prior to the beginning of the calendar year; and
 - f. Eligibility is certified until the end of the calendar year in which the application was filed.

0372.05.20 Qualified Disabled & Working Indiv (QDWI)

REV:09/2010

A. QDWIs were established under the legal authority of the Omnibus Budget Reconciliation Act (OBRA) of 1989 which allows disabled individuals who lose or have lost Medicare coverage solely because of work to buy it back. These individuals are called "Disabled Working Individuals." OBRA further requires states to pay the Part A Medicare premium for certain Disabled Working Individuals, called Qualified Disabled Working Individuals. The single benefit of this coverage is MA payment of the Medicare Part A premium. Qualified Disabled Working Individuals (QDWIs) are not otherwise eligible for Medical Assistance.

1. A Qualified Disabled and Working Individual (QDWI) is an individual or member of a couple who:
 - a. Is entitled and able to enroll, as determined by the Social Security Administration, in Medicare Part A as a disabled working individual;
 - b. Lost original entitlement to Medicare Part A through the loss of Title II benefits due to substantial gainful activity;
 - c. Has countable income of less than or equal to 200% of the Federal Poverty Level;
 - d. Has countable resources within twice the SSI limit;
 - e. Meets the citizenship/alienage, residency, enumeration, and third party resource requirements of the Medical Assistance Program; and,
 - f. Is NOT eligible for Medical Assistance under any other coverage provision.
2. Under this coverage group:

- a. Medical Assistance makes a direct payment to the federal government for Part A Medicare premiums. An individual cannot be reimbursed directly by Medical Assistance;
- b. Eligibility begins the month in which the application is filed and all eligibility requirements, including enrollment in Medicare Part A, are met;
- c. Eligibility may be determined and benefits granted for up to three (3) months prior to the month of application;
- e. Countable income and resources are determined using SSI-related methodology (See DHS Manual Sections 0356 and 0364),
- f. Income limits are rigid. There is no flexible test of income.

0372.05.25 Eligibility Determination

REV:09/2010

- A. For eligibility under the Medicare Premium Payment Program to exist, an individual or member of a couple must meet the non-financial requirements of citizenship, alienage, residency, enumeration and third party resource requirements that all other Medical Assistance applicants must meet, as well as the specific requirements of the Medicare Premium Payment Program: Enrollment in Medicare Part A, income and resources limits.
- B. An individual or member of a couple may qualify for Medicare Premium Payment Program benefits regardless of living arrangement. Income and resource limits are uniform, and do not vary depending on living arrangement or institutional status.
- C. An individual may apply for the Medicare Premium Payment Program only, Medical Assistance only, or both Medical Assistance and Medicare Premium Payment Program benefits. If eligible, the applicant is certified at his/her option for:
 1. Medicare Premium Payment Program Benefits only;
 2. Medical Assistance only; or
 3. Medical Assistance with QMB/SLMB. (QIs and QDWIs are not eligible for Medical Assistance.)
- D. Notices of agency action to applicants for Medicare Premium Payment Program benefits parallel the notices sent regarding actions on Medical Assistance applications. Applicants for Medicare Premium Payment Program benefits must receive adequate notice of agency action to accept or reject an application for such coverage.
 1. The agency must send timely and adequate notice of benefit termination. The notice must be mailed at least ten (10) days prior to the effective date of the action.
 2. Applicants/recipients requesting or receiving Medicare Premium Payment Program benefits are entitled to the same due process protection afforded other Medical Assistance applicants and recipients.

0372.05.30 Application Process

REV:09/2010

A. There are three distinct application processes for individuals and members of couples who are requesting Medicare Premium Payment Program benefits.

1. DHS provides the following two application processes:
 - a. Combined Application (Forms DHS-1 and DHS-2)
 - i. Individuals and couples applying for all covered Medical Assistance benefits complete the DHS-1 (Application) and DHS-2 (Statement of Need) forms.
 - ii. Such applicant is entitled to have eligibility determined under any and all coverage groups for which he/she may qualify, including Medicare Premium Payment Program benefits.
 - iii. Information about the benefits available under each appropriate coverage group must be provided to the individual at the time of application.
 - iv. If an applicant does not specifically and voluntarily choose to have his/her eligibility determined under a specific coverage group only, eligibility is determined for all potential coverage groups.
 - b. Streamlined Application (Form MPP-1)
 - i. Individuals and couples applying only for Medicare Premium Payment Program benefits may complete the MPP-1 application form and mail it to the DHS office.
2. The Social Security Administration (SSA) provides the third application process:
 - a. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), P.L. 110-275, section 113 states that the SSA is directed to transmit data from the Medicare Part D Low-Income Subsidy (LIS) application, with the consent of the applicant, to the Medicaid agency for purposes of initiating an application for the Medicare Savings Programs (MSP).
 - b. MIPPA requires the Centers for Medicare and Medicaid Services (CMS) to make available to SSA and the States, MSP model applications that can be provided to beneficiaries upon their request. The SSA has provided the CMS-designed model application in ten languages, other than English. If a state receives a model MSP application in any language, it is treated as an application for MSP.
 - c. Upon receiving an MSP application in the form of the LIS data transmission from SSA, DHS acts upon it in the same manner, and in accordance with the same deadlines, as if the data were an application submitted directly by the applicant to DHS.
 - i. DHS is required to act on this data as an application for MSP benefits, even if the LIS application was denied by SSA.
 - ii. DHS is required to treat these as applications for the MSP program even if it is an application not previously seen by staff at DHS.
 - d. A finding of eligibility or ineligibility is made for each application, unless the individual withdraws the application or is deceased.

- e. The date of electronic transmission of the LIS application from SSA to DHS is the date of the MSP application.
- B. To reduce barriers to eligibility for Medicare Premium Payment Program applicants, required verification is obtained from the individual's Social Security record. The State Verification and Exchange System (SVES) is used whenever possible to verify the applicant's date of birth, residency, social security number, social security income, Medicare Claim Number and Medicare Enrollment. Citizenship/alienage is pre-determined by the Social Security Administration and that requirement is met with Medicare enrollment. This verification must be obtained before eligibility is approved.
- C. Initial eligibility is not delayed while verification of income other than Social Security and resources is pending, providing that the information contained in the application does not conflict with other information provided by the applicant, information contained in other DHS applications, or other documented information known to DHS.
- D. Income other than Social Security and resources are verified with the applicant's consent by DHS Health Care Quality, Financing and Purchasing personnel at Central Office. As a condition of continued eligibility, the applicant/recipient must cooperate in the verification process by either:
 - 1. providing verification of income and resources
 - 2. giving consent to DHS to obtain such verification
- E. Information and/or documentation obtained in verification process is referred to the appropriate DHS field office for any necessary action.
- F. A decision on an application for Medicare Premium Payment Program benefits must be made within thirty (30) days of the receipt of the signed application form in the DHS office.
 - i. MSP application received in the form of the LIS data transmission from SSA does not require a signature.

0372.05.35 Financial Requirements

REV:09/2010

- A. The resource and income evaluation methods described in Sections 0356 and 0364 for SSI-related individuals are used to determine countable income and countable resources for Medicare Premium Payment Program applicants.

0372.05.35.05 Resource Limits

REV:02/2013

- A. Section 1905(p)(1)(C) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) has been amended to make the resource limit for QMB, SLMB and QI-1s conform to the resource limit for individuals who qualify for the full subsidy Medicare Part D Low-Income Subsidy (LIS), less the disregard for burial funds. The

Medicare Part D LIS resource limits are adjusted on January 1 of each year, based upon the change in the annual consumer price index (CPI) since September of the previous year. States must use the new resource limits when determining eligibility for these programs.

1. The basic resource limits for QMB/SLMB/QI-1 status are:
 - a. \$7,080 for an individual
 - b. \$10,620 for a couple
 2. The resource limit for QDWI, was not changed by MIPPA. The resource limit remains within twice the SSI limit:
 - a. \$4,000 for an individual
 - b. \$6,000 for a couple
- B. Resource exclusions, including those for life insurance, automobile, tangible personal property/household goods, burial contracts, and funds set aside for burial are identical to those of the SSI program. Refer to Section 0354.35 for Exclusions for Categorically Needy SSI-related individuals and couples.

0372.05.35.10 Income Limits

REV:09/2010

- A. The income limits for the Medicare Premium Payment Program benefits, based on the Federal Poverty (FPL) Guidelines for the appropriate family size, are listed below.
1. QMB - less than or equal to one hundred (100%) percent of FPL
 2. SLMB - greater than one hundred (100%) percent FPL and less than or equal to one hundred twenty (120%) percent of FPL
 3. QI-1 - greater than one hundred twenty (120%) FPL and less than one hundred thirty five (135%) percent FPL
 4. QWDI - less than or equal to two hundred (200%) percent of FPL

0372.05.35.15 Title II COLA Disregard

REV:09/2010

- A. For QMBs, SLMBs, and QI-1s, the cost-of-living increases in Title II benefits (COLAs), effective in January each year, are disregarded in determining income eligibility through the month following the month in which the annual Federal Poverty Level update is published.
- B. Only Title II COLAs are disregarded in this manner. This exclusion does not apply to cost-of-living adjustments in other types of income, such as government or private retirement pensions.

0372.10 LIST & DEFINITIONS OF LIMITED BENEFIT GROUPS

REV:02/2013

- A. The following information describes the various categories of individuals who are entitled to Medicare and eligible for some category of Medical Assistance limited benefits.
1. Qualified Medicare Beneficiaries (QMBs) - Individuals entitled to Part A of Medicare, with income not exceeding 100% of the Federal poverty level, and resources not exceeding the limit set for the full subsidy Medicare Part D Low-Income Subsidy (currently \$7,080 for an individual and \$10,620 for a

couple). QMBs may be eligible for full Medical Assistance or may have MA eligibility limited to payment of Medicare Part A and Part B premiums and Medicare cost-sharing (deductibles and coinsurance) for Medicare services provided by Medicare providers.

- a. QMBs without other Medical Assistance (QMB Only) - Individuals entitled to Part A of Medicare, with income not exceeding 100% FPL, and resources not exceeding \$7,080 (\$10,620 for a couple). Eligibility for MA is limited to payment of Medicare Part A and Part B premiums and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.
 - b. QMBs with Medical Assistance (QMB Plus MA) - Individuals entitled to Part A of Medicare, with income not exceeding 100% FPL, and resources not exceeding \$7,080 (\$10,620 for a couple). Eligibility for Medical Assistance includes payment of Medicare Part A and Part B premiums and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.
 - c. Non-QMBs - In addition, there are individuals who are eligible for Medicare and Medical Assistance, but who are not eligible under any of the special Medicare categories. Typically, these are Medicare eligible individuals whose income exceeds the income limits of any of the special categories and who spend down income to become eligible for MA. MA benefits are for MA services provided by MA providers, but only to the extent that the MA payment rate exceeds any Medicare payment for the service covered by both Medicare and MA.
2. Specified Low-income Medicare Beneficiaries (SLMBs) - Individuals entitled to Part A of Medicare, with income above 100%, but not exceeding 120% FPL, and resources not exceeding \$7,080 (\$10,620 for a couple). Eligibility for MA benefits is limited to payment of Medicare Part B premiums.
 3. Qualifying Individuals-1 (QI-1s) - Individuals entitled to Part A of Medicare, with income above 120%, but less than 135% FPL, resources not exceeding \$7,080 (\$10,620 for a couple), and not otherwise eligible for Medical Assistance. Eligibility for MA benefits is limited to full payment of Medicare Part B premiums. The QI-1 program is subject to federal appropriations.
 4. Qualified Disabled and Working Individuals (QDWIs) - Individuals entitled to purchase Part A of Medicare (Medicare benefits lost because of return to work), with income below 200% FPL, and resources not exceeding \$4,000 (\$6,000 for a couple), and not otherwise eligible for MA. Eligibility for MA benefits is

limited to payment of Medicare Part A

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Title XV Coverage Group

REV:09/2010

- A. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), amended Title XIX to include an optional Medicaid coverage group for uninsured women under age sixty-five (65) who are screened under the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and found to need treatment for breast or cervical cancer or for

precancerous conditions of the breast or cervix. Effective April 2001 and retroactive to January 1, 2001, Medical Assistance is provided to women who meet the specific eligibility requirements for this coverage group.

0372.20.05 Definitions

REV:09/2010

For purposes of this policy, the following definitions apply:

CREDITABLE COVERAGE means the term as it is defined in section 2701 of the Public Health Service Act, known as the Health Insurance Portability and Accountability Act of 1996, or HIPAA.

Creditable coverage includes, for example, most health insurance coverage (including insurance that may have high deductibles or limits), a group health plan, Medicare, Medicaid, Armed forces insurance, a medical program of the Indian Health Service (IHS) or of a tribal organization, and a state health risk pool.

However, for purposes of this policy, creditable coverage does not include plans which do not provide coverage for the treatment of breast or cervical cancer, or plans which provide only dental, vision, or long term care coverage, or plans which provide coverage only for a specified disease or illness. Further, if a woman is in period of exclusion (such as a pre-existing condition exclusion or an HMO affiliation period) for treatment of breast or cervical cancer or if she has exhausted her lifetime limit on all benefits under her health plan, she is not considered to have creditable coverage for purposes of this policy.

SCREENED FOR BREAST OR CERVICAL CANCER UNDER THE CDC BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM ESTABLISHED UNDER TITLE XV OF THE PUBLIC HEALTH SERVICE ACT means: a. A woman's clinical services were funded all or in part by CDC

Title XV funds b. she was screened under the RI Department of Health (HEALTH)

Women's Cancer Screening Program (even if their particular clinical service was not paid for by CDC Title XV funds) c. she was screened by a HEALTH designated provider and subsequently enrolled in the HEALTH Women's Cancer Screening Program.

NEED TREATMENT means that the diagnostic test following a breast or cervical cancer screen indicates that the woman is in need of cancer treatment services as verified by the RI Department of Health Women's Cancer Screening Program. These services include diagnostic services that may be necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Based on the physicians' plan-of-care, women who are determined to require only routine monitoring services for a precancerous condition of the breast or cervix (e.g., breast exams and mammograms) are not considered to need treatment.

COURSE OF TREATMENT means the period of time a woman requires treatment for breast or cervical cancer, or a precancerous condition of the

breast or cervix, as specified in writing by the woman's treating physician or nurse practitioner.

0372.20.10 Scope of Services

REV:09/2010

Eligible members of this coverage group receive the full scope of services provided to categorically needy individuals. (Section 0300.20)

0372.20.15 Eligibility Requirements

REV:09/2010

A. Under this coverage group, Medical Assistance is provided to a woman who:

1. Is under age sixty-five (65); and
2. Was screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service (PHS) Act and found to need treatment for either breast or cervical cancer, or a precancerous condition of the breast or cervix; and
3. Does not otherwise have creditable coverage; and
4. Is not otherwise eligible for Medical Assistance as categorically needy; and
5. Meets the technical MA requirements of residence, citizenship/immigration status, and provision of a social security number (Section 0300.25.05) and the cooperation MA requirements relating to provision of information needed for an eligibility determination and assignment of rights to third party payments for medical care (Section 0300.25.15).

0372.20.15.05 No Income or Resource Test

REV:09/2010

A. A woman must meet certain financial criteria in order to qualify for screening under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program and the Rhode Island Department of Health Women's Cancer Screening Program. The Department of Health Women's Cancer Screening Program, or its designees, are responsible for determining eligibility for screening under these programs.

B. However, there are no separate Medical Assistance Income or Resource Limits for this group.

0372.20.20 Presumptive Eligibility

REV:09/2010

A. Presumptive eligibility is a Title XIX option that permits states to enroll women in Medical Assistance (MA) for a limited period of time before a full application is processed, based on a determination of a qualified entity of likely MA eligibility.

1. This allows early access to health care for women found through screening to need cancer treatment.
2. Presumptive eligibility is granted if, based on information contained on the MA/Title XV Application Form (MA/BCC-1) and information provided by the health care provider conducting the screening, the RI Department of Health (HEALTH) Women's Cancer Screening Program determines that the woman:
 - a. is under age sixty-five (65)
 - b. has no other form of individual or group health insurance (including Medical Assistance)
 - c. needs treatment for breast or cervical cancer or a precancerous condition of the breast or cervix
 - d. resides in RI
3. Presumptive eligibility begins on the date Department of Health determines that the woman appears to meet above criteria.
4. Presumptive eligibility ends on the date a formal determination is made on the woman's application for MA, or if she does not file an MA application, on the last day of the month following the month in which presumptive eligibility begins.
5. DHS is responsible for providing the Department of Health Women's Cancer Screening Program with MA application forms and information on how to assist applicants in completing and filing such forms. The Department of Health Women's Cancer Screening Program, or its designees are responsible for providing the woman with assistance in completing and filing an MA application form (MA/BCC-1). The Department of Health Women's Cancer Screening Program is further responsible for:
 - a. making determinations of presumptive eligibility based on information provided on the MA/BCC-1
 - b. providing the woman with written notification of presumptive eligibility
 - c. notifying DHS within five (5) days of determinations of presumptive eligibility.
6. If a woman is determined not to be presumptively eligible, the Department of Health Women's Cancer Screening Program provides the applicant with written notification of the following:
 - a. the reason for the determination
 - b. that she may file a formal application for Medical Assistance and where she may apply for Medical Assistance
 - c. that a formal determination of MA eligibility will be issued by DHS based on her completed MA application
 - d. if she does not file an MA application, her presumptive eligibility ends on the last day of the month following the month presumptive eligibility began.
7. There are no appeal rights associated with determinations of presumptive eligibility. However, appeal rights do apply to the application for Medical Assistance.

0372.20.25 Application Process

REV:09/2010

A. The MA/BCC-1, a streamlined mail-in application form, is used to determine eligibility for MA under this coverage group.

1. Verification of immigration status must be provided by the applicant before MA eligibility is established.

- a. In addition, verification of the woman's eligibility for screening under the CDC Breast and Cervical Cancer Early Detection Program and her need for treatment is required before MA eligibility is established.
 - b. However, up-front verification of other information on the application form is not required unless it is inconsistent with that provided on previous DHS applications or with other documented information known to DHS.
2. Applications for Medical Assistance are available at the Department of Health Women's Cancer Screening Program, DHS offices, and at other DHS designated locations.
 3. The Center for Adult Health is responsible for determinations of MA eligibility for this coverage group. Individuals identified by the Center for Adult Health as potentially eligibility for MA under another categorically needy coverage group must cooperate in filing a full MA application (DHS-1/DHS-2 or MARC-1 as appropriate) as a condition of maintaining MA eligibility.
 4. Eligibility decisions are made in accordance with provisions contained in Section 0302.15. If the applicant indicates that an unpaid medical bill was incurred in the three (3) month period preceding application, eligibility for retroactive coverage is determined. To qualify for retroactive coverage, the applicant must meet all eligibility requirements during the retroactive period.

0372.20.30 Redeterminations

REV:09/2010

- A. A redetermination of MA eligibility must be made periodically to determine that the recipient continues to meet all eligibility requirements. The redetermination of eligibility is based on information provided on a new application form and documentation from the woman's treating physician regarding her course of treatment. If a woman's course of treatment for breast or cervical cancer (or for a precancerous condition of the breast or cervix) has ended, or if verification of the need for continuing treatment is not provided within the time frame specified, eligibility is discontinued.
1. A full redetermination of eligibility must be made at least every twelve (12) months, or whenever a change in circumstances occurs, or is expected to occur, that may affect eligibility.
 2. Interim verification of continuing treatment, based on the reasonable expectation of the length of a woman's course of treatment, is also required. Unless otherwise specified by the woman's treating physician or nurse practitioner, the expected length of time for treatment of a pre-cancerous condition is four (4) months.

0372.20.35 When Eligibility Ends

REV:09/2010

- A. Eligibility for MA under this coverage group ends if:
 1. the woman attains age sixty-five (65)

2. she acquires creditable coverage
3. her course of treatment for breast or cervical cancer ends
4. she fails to complete a scheduled redetermination
5. she is no longer a RI resident
6. she otherwise does not meet the eligibility requirements for the program.

B. MA notification and appeal rights apply to individuals losing eligibility under this coverage group.