



Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd floor, Cranston, RI 02920
phone: 401.462.2132 fax: 401.462.0458

May 20, 2015

Docket # 15-632

Hearing Date: April 21, 2015



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided partially in your favor. During the course of the proceeding, the following issue(s) and Agency regulation(s) were the matters before the hearing:

**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION 0372 SPECIAL TREATMENT COVERAGE GROUPS
SECTION 0362.05 INCOME STANDARDS**

**CFR Title 42; Public Health
Part 407.4, Part 407.10, Part 407.40
POMs HI-00801.140, HI01001.205, HI 00815.009**

The facts of your case, the Agency regulations, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: You, Your attorney, and Agency representatives: Kristen Grosso, Robin Barradas, Betty Perez, and Denise Tatro.

Present at the hearing were: Your attorney, and Agency representatives: Kristen Grosso, and Robin Barradas.

ISSUES:

- 1. Should the Agency be required to render a decision as to MPP (Medicare Premium Payment) program eligibility when a Medicaid applicant is enrolled only in Medicare Part A insurance?**
- 2. Does the absence of Medicare Part B result in ineligibility for MPP eligibility?**
- 3. Is the Agency required to enroll the Medicaid applicant in Medicare Part B if he is found to be QMB eligible?**

EOHHS RULES AND REGULATIONS:

Please see the attached APPENDIX for pertinent excerpts from Rhode Island Executive Office of Health and Human Services Medicaid Code of Administrative Rules (MCAR).

APPEAL RIGHTS:

Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

DISCUSSION OF THE EVIDENCE:

The appellant through his attorney testified:

We (appellant and DHS) are in agreement with the following facts 1-14:

1. The state got a DHS-2 in December (2014).
2. At the time they got the DHS-2, he (appellant) was enrolled in Part A Medicare, but not Part B, as shown by the medi-panel.
3. They sent a notice December 29th and found him categorically eligible for Medicaid because he is under 100% of the federal poverty limits with an income of \$535.00 gross. The notice did not say anything about MPP.
4. Regulations 372.5 reference shows his income within 100% of poverty and QMB (Qualified Medicare Beneficiary) limits.
5. At the time of the hearing request on February 4, 2015 OHHS had not issued a decision one way or the other on MPP eligibility.
6. After that OHHS sent a notice dated March 11th denying MPP.
7. We appealed on April 16 and requested the two notices be consolidated.
8. The medi-panel shows that he'll be enrolled in Part B starting July 1st.
9. The reason for the denial of MPP in March is actually that

he was not enrolled in Part B in December, and that he will not be enrolled until July 1st.

10. We are in agreement that he had Part B and voluntarily withdrew in January 2011.

- We argue that the state should have done something earlier.
- We argue that the December application was an application for all forms of Medicaid including MPP, as a DHS-2 under the regs. (regulations) is an MPP application and, he should have gotten a decision within thirty days, mooted out by the fact that he was sent a decision after that.
- Regulation 372.05.30 says that an applicant is entitled to have eligibility determined under any and all Medicaid coverage groups for which he may qualify-including MPPP.
- We agree he was enrolled in Part A, but it is important to know he was eligible for, and entitled to Part B even though he was not enrolled in it, as referenced by 42CFR407.4 and 42CFR407.10.
- In addition he met the QMB requirements of 372.05.05-he was enrolled in or entitled to Part A, had countable resources within the limits, income up to 100% of poverty, and the other general requirements. The regulations do not say anything about having to be enrolled in Part B.
- Under those QMB regulations eligibility begins on the first day of the month after an application is filed, and we say the application was filed in December as an MPPP application even though the state did not treat it like that.
- We say that RI is required to enroll QMB's in Part B, not just pay the premiums, but enroll them and buy them in when they get an application, notify the Feds that they are going to pay the premium and actually enroll.
- What we have is Federal regulation 42CFR407.40 which says that states can enter agreements with the Secretary to enroll people in the SMI (supplementary medical insurance) program which is Part B-for certain individuals who are eligible for Part B and who are members of the buy-in, and under that regulation, QMBs is one of those buy-in categories.
- POMS HI-801.140 says that when QMB provisions were enacted, states were given the option of expanding buy-in agreements to cover QMB for Part B, thereby permitting QMBs to be enrolled in Part B without regard to the enrollment period. Based on what we have seen in the Social Security POMS (Program Operations Manual) it looks like RI elected to cover QMB's for buy-in, and RI is listed as a buy in state.

- Although the general enrollment for Part B is January through March of every year, we argue that this does not apply to state buy-in or MPP-states who can enroll anytime of the year for QMBs.
- There is also Social Security Administration Policy instruction for individuals in Part A buy-in states who do not have Medicare Part B which also indicates that when an individual resides in a Part A buy-in state like RI, the application does not have to be filed in an enrollment period, but could be filed at any time, suggesting that the state is supposed to enroll the person and pay the Part B premium if he is a QMB, which he is.
- Finally, there is a state buy-in POMS-HI 01001.205 which indicates that if the state has bought in, and it appears RI has bought in on QMBs, then the state is required to enroll and pay the medical insurance premiums for Part B.
- There is a policy reason behind this because there is a Medicaid cost savings when you get people in Part B, because the Medicare picks up 80% of the doctor's visits, etc., so it's a cost shifting thing to get the money away from state payment onto Federal payment and get people enrolled in Medicare so Medicare pays.
- The main point is that they should have approved him for MPP and enrolled him in Part B back then because he is a QMB, and then he would get his premiums paid January through June, an extra six months premium paid by the state.
- We are all in agreement that he will be enrolled in Part B as of July 1st, so we are just looking for that from the time of application.
- We would object to having the hearing continued to allow Legal representation for DHS because we sent an email on February 11th to Robin Barradas and Betty Murray and informed them of the POMS, and suggested they double check with the Feds, and maybe we could resolve this. That was the time, and not today for someone else to get back to us, to check with the Feds, to check with legal, and to get someone involved in this and get back to us. This has been going on since February 4th, and in our experience in the past, we have dealt with Betty Murray, who has been aware of the issue since the February e-mail. We got no response.
- We agree there is nothing in the DHS manual that says OHHS **shall** enroll. We think that the Federal regs. do suggest that because of the QMB buy-in, that's what they are supposed to do.
- When they get a DHS-2 they've got to make a decision one way or the other.
- People drop Part B often because it's too expensive and comes out of their fixed income. There is no prohibition about coming back in and enrolling in the general

enrollment period January through March, which would make you eligible as of July 1st.

- There should be no late penalties for MPP people. The state does not pay a late enrollment penalty for them, because that's the benefit of coming into a buy-in program and getting states to approve MPP-whether they are three years later or ten years later.

The DHS representatives testified:

- We are in agreement with the facts as stated in the record (1-14 above).
- He (the appellant) was enrolled in Part B but voluntarily withdrew for reasons unknown, in January 2011, and due to the fact that he did have it, Social Security is stating that instead of putting him into a yearly per month increased premium payment they are making him wait until July 2015.
- The Medicare.gov website printout states what happens if you had Part B and dropped it, and what happens if you don't have it. It explains steps needed for enrollment, and what is needed if you withdrew and want to get it back.
- DHS website states that under the Medicare Premium Payment Program, that if you have Medicare then EOHHS Medicaid program could help you with the costs.
- Basically, you have to be enrolled in Part B in order to for the state through DHS to pay the monthly premium.
- Our application for Medicare Premium Payment (MPP-1) nowhere states that we will enroll you in Part B. It's specifically pertaining to the premium payment being paid for-not an enrollment for Medicare.
- DHS does not give you eligibility for the Medicare Part B Premium unless you're receiving Medicare Part B, and Medicare gives us that information.
- It's the Agency's position that we cannot give you eligibility for a program that you're actually not enrolled in with Medicare.
- We believe that the appellant's argument is with the wrong Agency, and that they need to be contacting Medicare to see if there are any penalties they could waive in order to go back to December.
- In the event that happens, we would be more than happy to go back to December to re-determine eligibility, to start paying the MPP at that time.
- If there are Federal regulations, and laws, we at the field level don't interpret or

set policy. Our role is strictly eligibility and I would prefer that these regulatory issues go to DHS legal. I did not think there would be a hearing today, and if Legal Services is presenting that our Agency is not adhering to Federal Regulations then someone in the Agency, whether it be legal or policy would be the people who would need to answer to that. Upon receipt of the February 11 (2014) email from Legal Services, we did "bump" this issue up to the Regional Manager, and it was our understanding that in the past Legal Services and our Legal Department spoke with one another.

- I may have misread an email (from Legal Services) and I don't disagree with their contention that they sent an email which said let's settle on the facts so we don't need to have testifying but just presentation of the legal arguments.
- The client must go to Social Security directly to get enrollment in Part B and it is dependent upon where they are in open enrollment, with penalties, time frames, etc. They then generally would contact us and ask us to help them with the premium. They determine what the payment is prior to coming to DHS, because the rates are set at the Social Security end.

FINDINGS OF FACT:

- The appellant voluntarily withdrew from Part B Medicare insurance in December 2010, and was informed by Social Security Administration he could re-enroll during any annual general enrollment January through March.
- The appellant filed a December 15, 2014 DHS-2 application. At the time of application he was enrolled in Part A Medicare insurance, but not enrolled in Part B.
- A DHS-2 is one of three methods of application for those requesting MPPP benefits. Per regulations 0372.05.30 the DHS-2 is an application which allows eligibility determinations for all Medicaid coverage groups.
- A December 29, 2014 Medical Assistance (MA) eligibility notice found the appellant categorically eligible for MA as of December 1, 2014 based upon his monthly income which was below 100% of the FPL. The notice did not assess the appellant for MPP coverage.
- On February 4, 2015 the appellant appealed the omission of a determination of MPP eligibility, and requested to be enrolled in Part B, and have Part B paid for.
- A March 11, 2015 notice denied the appellant for MPP. The Agency verbally identified that the denial was based upon the appellant's lack of enrollment in Part B Medicare insurance. The original December notice and subsequent February appeal was used for purposes of this hearing both for the application date, and for the omission of MPP eligibility on the MA notice.

- OHHS regulations 0372 identify that MPP eligibility requires enrollment or entitlement to Part A Medicare insurance, but does not specify a need for enrollment in Part B.
- A hearing was held on April 21, 2015.

CONCLUSION:

The issues to be decided are:

1. Whether the Agency should be required to render a decision as to MPP (Medicare Premium Payment) program eligibility when a Medicaid applicant is enrolled only in Medicare Part A insurance.
2. Whether the absence of Medicare Part B results in ineligibility for MPP eligibility.
3. Whether the Agency is required to enroll the Medicaid applicant in Medicare Part B if he is found to be QMB eligible.

The statutory foundations of the Rhode Island Medicaid program are Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), Rhode Island General Laws 40-8, and Rhode Island General Laws 42-7.2. The Office of Health and Human Services (OHHS) is the State Agency responsible for administering the State's Medicaid program and the Medicaid Code of Administrative Rules (MCAR) is the OHHS's official code of rules, regulations and procedures for the Medicaid Program. Rhode Island Executive Office of Health and Human Services is the single State agency designated to administer and supervise the administration of the Medicaid program (Medical Assistance) under Title XIX of the Social Security Act. The RI Department of Human Services, however, continues to be responsible for determinations of eligibility for the Medical Assistance program including the MPP program.

The appellant applied for Medical Assistance through a DHS-2 application in December 2014. He received a December 29th notice indicating he was eligible for Medical Assistance (MA) beginning on December 1, 2014. The appellant appealed this decision citing the omission of an eligibility finding for the MPP (Medicare Premium Payment) program. He further argued that he thought he was eligible to be enrolled in Part B and have Part B paid for. The Agency and the appellant agreed that his subsequent denial for MPP eligibility was due to his lack of Part B enrollment.

There is no dispute between the Agency and the appellant that the appellant was found eligible for Medicaid. There is no disagreement that the appellant was enrolled in Part A Medicare, but not enrolled in Part B at the time of the Medicaid application. There is no disagreement that as of January 2011 the appellant had voluntarily withdrawn from Part B of his Medicare insurance. There is no dispute that the record establishes that the appellant dis-enrolled and will be re-enrolled and eligible as of July 1, 2015.

The first issue in dispute is the lack of an MPP eligibility determination by DHS upon receipt of the DHS-2. The appellant argues that the Agency is required to make a decision "one way or the other", and that the DHS-2 is to be considered an application for **all** categories of medical assistance for which he may be eligible-including MPP. He further contends that the decision should have been rendered within a thirty day period. The Agency argues that the MPP-1 is the application with which to assess MPP eligibility.

A review of the regulations (0372.05.30) notes three "distinct" methods of application for those requesting Medicare Premium Payment Program benefits-two of which are through DHS. The MPP-1 is the "streamlined" application for MPP benefits only. The DHS-2 is for applicants applying "for all covered Medicaid benefits." Regulations specifically note that eligibility determinations under the DHS-2 should be made for all coverage groups "including Medicare Premium Payment Program benefits." Review of policy further directs that a decision of eligibility for MPP benefits must be made within thirty days of the receipt of the signed application form in the Medicaid agency office. In conclusion, the Agency was thereby required to accept the DHS-2 as an application for all Medicaid coverage groups, and to make a determination in this case, for MPP eligibility within the time frames.

While the Agency did not render an MPP decision within 30 days of receipt of the Medicaid application, a decision was issued during the appeals process denying MPP eligibility because he was not enrolled in Part B. The appellant appealed that decision, and per his request, his two appeals were combined into this hearing.

The Agency contends that MPP eligibility is for payment of Part B premiums, and if the appellant is not enrolled in Part B he has no need for assistance, and is therefore ineligible for MPP. The Agency argues that to have payment assistance for Part B through DHS, one has to first be enrolled in Part B-which the appellant was not. The appellant argues that his current enrollment in Medicare Part A and his eligibility to enroll in Part B qualifies him for MPP if he meets all of the other requirements. The appellant argues that he had Part B, voluntarily withdrew from it, and that there is no prohibition for recipients from coming back in and enrolling during the general enrollment period. He cites 42CFR407.4 and 407.10 which allows for eligibility for Part B for the appellant based upon his entitlement to hospital insurance (Part A) which he had.

Medicare is a two part Federal Health insurance to which individuals who are insured under the Social Security system are entitled once they reach the age of 65 or they reach the 25th month of a permanent and total disability. Exploration of the OHHS regulations cite that to qualify for MPP eligibility an individual must meet the requirements which include enrollment or entitlement in Medicare Part A. The regulations do not require enrollment in Part B for eligibility to be determined. The MPP program pays some or all of the costs of Medicare Part A and Part B premiums, deductibles, and copayments. Thus eligibility might entail assistance with other areas of medical need in addition to paying Part B premiums. In conclusion, the

absence of enrollment in Medicare Part B does not automatically disqualify the applicant for MPP eligibility.

The third issue argued, is that, if eligible for QMB, which the appellant believes he is, is the Agency required to enroll him in Part B? The Agency presents that the MPP-1 application does not require DHS to enroll the applicant in Part B. They argue that they are to make the determination for eligibility for QMB and that Social Security is responsible to enroll. They note a December 2010 Social Security Administration (SSA) letter sent to the appellant and submitted into evidence which states the appellant voluntarily withdrew from the Part B coverage, and could, in the future, have Part B again if he waited for the general enrollment period in any year January through March, resulting in coverage beginning on July 1st. They note that the appellant originally went through Social Security to both obtain and then withdraw from the Medicare assistance. They further argue that Social Security Agency makes enrollment determinations taking into consideration time frames, penalties, and rate setting. The appellant argues that he is eligible for the coverage group-QMB (Qualified Medicare Beneficiary) as a result of meeting the following criteria: he is enrolled in Medicare Part A, he has countable resources within the limits required, his countable income falls below 100% of the FPL guidelines, he lived with his wife and minor children at the time of application, and he meets the other general requirements. As previously argued, the appellant thereby contends that the Agency must make an MPP eligibility finding as of the date of application which would mean QMB eligibility as of January 1, 2015. He argues that the Social Security POMS (Program Operational Manual) HI-801.140 identifies that when QMBs were enacted, states were given the options of expanding agreements to cover them for Part B, thereby permitting them to be enrolled without regard to the enrollment period. He further argues that RI is a buy in state, and by virtue of being a QMB in a buy in state, the Agency, per regulations 42CFR407.40, is required to enroll him in Part B. He concedes that the state regulations do not require DHS to enroll him in Part B, but the federal regulations do. He cites as well that POMs HI 01001.205 instructs that since the state has bought in for QMBs, then the state is required to enroll hi in Part B.

OHHS regulations 0372.05.05 support the appellant's contention that QMB's "eligibility begins on the first day of the month after the application is filed"...if all other eligibility requirements are also met. Exploration of CFR407.4 examines those basic requirements for entitlement to SMI (Supplementary Medical Insurance-Part B). First, the applicant must meet the eligibility requirements and second, the applicant must enroll or must be enrolled by a State under a buy-in agreement.

Section 1843 of the Social Security Act permitted states to enter into an agreement with the Secretary to enroll certain individuals in the SMI program who were eligible and who were members of the buy-in group specified in the agreement. The Act was amended in 1981 to allow states not already in, to buy-in, or to request broader coverage groups for existing agreements. Several laws enacted 1980-1987 expanded the groups again, and in 1989 a new buy-in category consisting of QMBs was established. By definition, "state buy-in or buy-in agreement"...is an agreement under which a state secures SMI (Part B) or HI (Hospital insurance/Part A) coverage for individuals who are members of the buy-

in group specified in the agreement. A state with a buy-in agreement in effect must enroll any individual who is eligible to enroll in SMI under 407.10. In exploring the document submitted into evidence by the appellant, the state of RI is listed as a Part **A** (emphasis added) buy-in state for QMBs with premiums-HI for the Aged, which is a different group of QMBs, than those being discussed in this decision, and therefore is not relevant to this discussion. The background information cited in the document identifies that when the QMB provisions were enacted in 1989, states were given the option of expanding their state buy-in agreements to cover QMBs for SMI, "thereby permitting QMBs to be enrolled in SMI without regard to the enrollment period and premium increase provision applicable to enrollees. All states elected to cover QMBs for SMI." The manual allows that states were given options for QMBs, but also identifies that all states elected to cover QMBs for SMI (Part B). It does not specify that all states were considered buy-in states for this coverage group. There is no mention of a contractual buy-in agreement for Part B for the QMB category into which the appellant believes he belongs.

The POMs submitted, notes that states "**may** (emphasis added) enter into an agreement with SSA which permits"... agencies to enroll individuals for part B (SMI) coverage **and/or buy-in** for the payment of medical insurance premiums **if** (emphasis added) the individual is a member of a coverage group. Once states have contracted an agreement with the Administration, the state is required to "enroll and/or pay the medical insurance premiums for each individual eligible under the titles included in its contract." The POMs clarifies that states negotiate different types of agreements, and buy-ins are for several different types of enrollees dependent upon the type of agreement the state has negotiated. Further exploration of POMs HI 00815.006 indicates that the state must sign a buy-in agreement with the Secretary of Health and Human Services specifying the category of Medicaid recipients for whom it wishes to buy-in, and to whom they would be required to enroll. The issue then, for the appellant, is what type of buy-in agreement/contract is, or was, in place. Although the appellant gives reasonable argument to consideration for enrollment by the state, he failed to provide any evidence of a contract in which the state agreed to enroll individuals in Part B at the time of their Medicaid application. Therefore, the appellant was unable to support his contention that the Agency was responsible to enroll him in Part B.

The appellant further presented a 2013 SSA policy instruction which considered applicants who did not have Part A or Part B. In this case currently being presented the appellant does have Part A, rendering the Policy instructions irrelevant to this discussion.

In summary, the appellant's contention was that because RI is a buy in state, he is allowed, due to his eligibility for Part B coverage, and his subsequent QMB eligibility, to be enrolled by the state without consideration for any enrollment periods. The appellant was unable to establish what, if any, specific buy in agreement is in existence for his particular QMB coverage group at this time, as the evidence did not support his claims. Additionally, the appellant was never found eligible as a member of this group, as his MPP denial resulted from the Agency's determination that he was not eligible for

consideration because he was not enrolled in Part B. Thus, the Agency never completed a QMB finding.

In conclusion, this hearing officer finds that the Agency should have determined the appellant's MPP eligibility within 30 days of receipt of the DHS-2 application, despite his lack of enrollment in Part B coverage at the time of application. The evidence record fails to establish that if found eligible for QMB, the Agency is then required to enroll the appellant in Part B.

After a careful review of the Agency's regulations, as well as the testimony presented, the Appeals Officer finds that the appellant's request for determination of MPP eligibility through the DHS-2 application is granted. The Officer finds as well, that MPP should be determined whether or not the appellant is currently enrolled in Part B Medicare.

After a careful review of the Agency's regulations, the POMs manuals, and the Federal regulations, the Appeals Officer finds that the appellant's request for the Agency to **enroll** (emphasis added) him in Part B Medicare Insurance is denied regardless of a finding of QMB status.

ACTION FOR THE AGENCY:

The Agency is to accept the December 2014 DHS-2 application for a determination of MPP eligibility, and they are to determine MPP eligibility without regard for current enrollment in Part B Medicare coverage. DHS is to remit a new notice reflecting acceptance or denial of eligibility for MPP as based upon this finding. In the event the appellant is found eligible for QMB the Agency is not required to enroll him in Part B.

A handwritten signature in black ink, appearing to read 'Karen Walsh', is written in a cursive style.

Karen Walsh
Appeals Officer

APPENDIX

MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)

0372 Special Treatment Coverage Groups

0372.05 Medicare Premium Payment Program (MPPP)

REV: 01/2014

Purpose: The Medicare Premium Payment Program helps elders 65 and older (and adults with disabilities) pay all or some of the costs of Medicare Part A and Part B premiums, deductibles and co-payments. Low income adults with disabilities who have Medicare coverage, may be eligible for the Medicare Premium Payment Program (MPPP). Medicare Part A is hospital insurance coverage and Medicare Part B is for physician services, durable medical equipment and outpatient services. A person's income and resource determine which type of Medicare premium assistance is available.

2. 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:

a. Part A Medicare Insurance

- Pays for hospital services and limited skilled nursing facility services;
- 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;
- Is available without charge to certain individuals who receive continuing dialysis for permanent kidney failure and certain individuals who have had a kidney transplant;
- 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.

b. Part B Medicare Insurance

- Pays for physician services, durable medical equipment and other outpatient services;
- 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.
- The Part B premium as of January 1, 2014 is \$104.90/month 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.

3. 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.

4. 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 Medicaid 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: 01/2014

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, Medicaid makes a direct payment to the federal government for the Part A premium (if any), the Part B premium, and provides payments for Medicare co-insurance and deductibles as long as the total amount paid by the Medicare Program does not exceed the Medicaid Program allowed amount(s) for the service(s). An individual may qualify for and receive QMB and full Medicaid 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 \$7,160 for an individual or \$10,750 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 Medicaid Program.
3. Under this coverage group:
 - a. Individuals cannot be reimbursed directly by Medicaid;
 - 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 (Medicaid Code of Administrative Rules (MCAR) 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

0372.05.30 Application Process

REV: August 2014

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

1. The Medicaid agency provides the following two application processes:

a. Combined Application (Forms DHS-1 and DHS-2) available at:

<http://www.eohhs.ri.gov/ReferenceCenter/FormsApplications/MedicaidApplication.aspx>

i. Individuals and couples applying for all covered Medicaid benefits complete the DHS-1 (Application) and DHS-2 (Statement of Need “Application for Assistance”) forms.

ii. An applicant is entitled to have eligibility determined under any and all Medicaid coverage groups for which the applicant may qualify, including Medicare Premium Payment Program benefits.

iii. Information about the benefits available under each coverage group must be provided to the individual at the time of application.

iv. If an applicant does not voluntarily choose to apply for Medicaid coverage under a specific coverage group, eligibility is determined for all potential coverage groups, as specified.

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 Medicaid agency office at the Hazard Building, 74 West Road, Cranston, Rhode Island 02920.

The application is available upon request and online at:

<http://www.eohhs.ri.gov/ReferenceCenter/FormsApplications/MedicaidApplication.aspx>

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 must 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 MPPP.

b. MIPPA requires the Centers for Medicare and Medicaid Services (CMS) to make available to SSA and the States, 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 application in any language, it is treated as an application for the MPPP.

c. Upon receiving an application in the form of the LIS data transmission from SSA, the Medicaid agency 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 agency.

i. The Medicaid agency is required to act on this data as an application for MPPP benefits, even if the LIS application was denied by SSA.

ii. The Medicaid agency is required to treat these as applications for the MPPP program even if it is an application not previously seen by staff at the Medicaid agency.

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 the Medicaid agency is the date of the MPPP 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/ immigration status 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 state agency applications, or other documented information known to the Medicaid agency.

D. Income other than Social Security and resources are verified with the applicant's consent by EOHHS. As a condition of continued eligibility, the applicant/ beneficiary must cooperate in the verification process by either: providing verification of income and resources or consent to the Medicaid agency to obtain such verification.

E. Information and/or documentation obtained in the verification process is referred to the appropriate staff 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 Medicaid agency office.

i. MPPP 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

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

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.

0362.05 Income Standards - Individual/Couple

REV: April 2014

The following standards are used in the determination of an individual's or couple's income eligibility:

2014 Monthly Federal Benefit Rate (FBR);

Categorically Needy Income Limits;

Medically Needy Monthly Income Limits;

2014 Federal Poverty Level Income Guidelines (for Low Income Aged and Disabled Individuals, Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries and Qualified Disabled and Working Individuals).

2014 Monthly Federal Benefit Rate (FBR)

Individual - Own Home \$721.00

Couple - Own Home \$1,082.00

Individual - Home of Another \$480.44

Couple - Home of Another \$721.33

"DIFFERENCE BETWEEN"

Couple and Individual - Own Home \$361.00

Couple and Individual - Home of Another \$240.89

"DOUBLE THE FBR"

Individual - Own Home \$1,442.00

Individual - Home of Another \$960.88

Couple - Own Home \$2,164.00

Couple - Home of Another \$1,442.66

Categorically Needy Net Monthly Income Limits for Aged, Blind, or Disabled Individuals/Couples

Income Limits Individual Couple

Living in a Nursing Facility or ICF-MR Facility

\$ 2,163.00¹ N/A

Living in Own Household \$ 760.92 \$ 1,161.38

Living in Household of Another \$ 532.36 \$ 818.63

¹ By federal law, to be eligible as "Categorically Needy" while living in a nursing facility, ICF-MR facility or a licensed residential care and assisted living facility, an individual's gross income cannot exceed 300% of the federal SSI level of payment for an individual.

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Income Limits Individual Couple

Living in a residential care and assisted living facility

\$ 2,163.00 ** **Treat as Individual

Institutionalized individual eligible for the federal and state Supplement

\$ 50.00 \$ 100.00

This is the FEDERAL CAP which is \$2,163 effective 01/01/ 2014.

TABLE OF MEDICALLY NEEDY MONTHLY INCOME LIMITS

1 Person \$ 858.00 5 Persons \$ 1,417.00

2 Persons \$ 900.00 6 Persons \$ 1,592.00

3 Persons \$ 1,108.00 7 Persons \$ 1,750.00

4 Persons \$ 1,258.00 8 Persons \$ 1,933.00

2014 FEDERAL POVERTY LEVEL MONTHLY INCOME GUIDELINES

100% of Federal Poverty Level Income Guidelines for Qualified Medicare Beneficiaries

(QMB's) and Low-Income Aged and Disabled

Individual \$ 972.50

Couple \$ 1310.83

120% of Federal Poverty Level Income Guidelines for Specified Low-Income Medicare Beneficiaries (SLMB's)

Individual \$ 1,167.00

Couple \$ 1,573.00

135% of Federal Poverty Level Income Guidelines for Qualified Individuals (QI-1)

Individual \$ 1,312.88

Couple \$ 1,769.63

200% of Federal Poverty Level Income Guidelines for Qualified Disabled and Working

Individuals (QDWI's)

Individual \$ 1,945.00

Couple \$ 2,621.67

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.