



RHODE ISLAND EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

Notice of Public Hearing and Public Review of Rules

The Secretary of the Executive Office of Health & Human Services (EOHHS) has under consideration amendments to six (6) sections of the Medicaid Code of Administrative Rules (“MCAR” or “Regulations”) as follows:

Rhode Island Medicaid Code of Administrative Rules:

Section 0300: Overview of the Rhode Island Medicaid and Children’s Health Insurance Programs

Section 0301: Payments and Providers

Section 0302: Medicaid Application – Integrated Health Care Coverage Groups

Section 0308: Cooperation Requirements

Section 0310: Retroactive Coverage

Section 0342: Medicaid Coverage for Children and Families

These regulations are being promulgated pursuant to the authority contained in Rhode Island General Laws Chapters 40-8 (Medical Assistance); 42-7.2 (Executive Office of Health & Human Services) and 40-6 (Public Assistance Act); Title XIX of the Social Security Act; Medicaid Section 1115 Demonstration Waiver; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15).

These proposed rule revisions are related to the Medicaid renewals/redeterminations that are scheduled to commence on August 1, 2014. The EOHHS rules posted for public comment on May 19, 2014 pertain to the Medicaid populations that will be subject to the modified adjusted gross income (MAGI) standard as part of the renewal process. These beneficiaries have been organized into the “Medicaid Affordable Care Coverage” groups. (See the Medicaid Code of Administrative Rules sections 1301 and 1303). The rules that are the subject of the present promulgation (from the #0300 series of the MCAR, as noted above) are amended to reflect the shift in eligibility requirements for this population of Medicaid beneficiaries and the application of the MAGI standard upon eligibility renewal.

In accordance with RIGL section 42-35-3, a hearing will be granted if requested by twenty-five (25) persons, or by an agency or an association having at least twenty-five (25) members. A request for a hearing must be made within thirty (30) days of this notice.

In the development of these proposed Regulations, consideration was given to the following: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small businesses in Rhode Island. No alternative approach, duplication or overlap, or impact upon small businesses was identified based upon available information.

These proposed documents are accessible on the Rhode Island Secretary of State’s website: <http://www.sos.ri.gov/ProposedRules/> and the EOHHS website www.eohhs.ri.gov or are available in hard copy upon request (401-462-1575 or RI Relay, dial 711). Interested persons should submit data, views, written comments, or a request for a hearing **by Friday,**

July 18, 2014 to: Elizabeth Shelov, Office of Policy and Innovation, Rhode Island Executive Office of Health & Human Services, Louis Pasteur Building, 57 Howard Avenue Room #142, Cranston, RI 02920 or Elizabeth.Shelov@ohhs.ri.gov.

The Rhode Island Executive Office of Health & Human Services in the Louis Pasteur Building is accessible to persons with disabilities. If communication assistance (readers /interpreters /captioners) is needed, or any other accommodation to ensure equal participation, please notify the Executive Office at (401) 462-6266 (hearing/speech impaired, dial 711) at least three (3) business days prior to the Public Hearing so arrangements can be made to provide such assistance at no cost to the person requesting.



Steven M. Costantino, Secretary
Signed this 17th day of June 2014

0300 Rhode Island Medicaid

Overview of the Rhode Island Medicaid and Children's Health Insurance Programs

REV: ~~October 2013~~ June 2014

0300. 01 A. Overview and Statutory Authority of the State Agency

Rhode Island General Laws Section 42-7.2-2 created the Rhode Island Executive Office of Health and Human Services (EOHHS) in 2006. ~~EOHHS sits within the executive branch of state government and~~ serves "as the principal agency of the executive branch of state government for managing the departments of children, youth and families, health, human services, and behavioral healthcare, developmental disabilities and hospitals." Toward this end, the EOHHS possesses, among others, the following duties and responsibilities:

Lead the state's four (4) health and human services departments in order to:

- Improve the economy, efficiency, coordination, and quality of health and human services policy and planning, budgeting, and financing;
- Design strategies and implement best practices that foster service access, consumer safety, and positive outcomes;
- Maximize and leverage funds from all available public and private sources, including federal financial participation, grants, and awards;
- Increase public confidence by conducting independent reviews of health and human services issues in order to promote accountability and coordination across departments;
- Ensure that state health and human services policies and programs are responsive to changing consumer needs and to the network of community providers that deliver assistive services and supports on their behalf. (See Rhode Island General Laws section 42-7.2-2 *et seq.*).

In addition, the EOHHS is responsible for administering the State's Medicaid program, which provides health care services and supports to a significant number of Rhode Islanders on an annual basis.

The statutory foundations of the Rhode Island Medicaid program are Title XIX of the Social Security Act (42 U.S.C. § 1396a *et seq.*), Rhode Island General Laws 40-8, and Rhode Island General Laws 42-7.2. Statutory authority for health care coverage funded in whole or in part by the federal Children's Health Insurance Program (CHIP) is derived from 42 U.S.C. § 1397aa *et seq.*, of the U. S. Social Security Act which establishes that program and provides the legal basis for providing health coverage, services and supports to certain targeted low-income children and pregnant women through Medicaid.

EOHHS is designated as the "single state agency", authorized under Title XIX ~~of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq.*)~~, and, as such, is legally responsible for the ~~program/~~ fiscal

management and administration of the Medicaid ~~Program~~ program. As health care coverage funded by CHIP is administered through the State's Medicaid program, the EOHHS also serves as the CHIP State Agency under federal and State laws and regulations.

The Medicaid and CHIP state plans and the Rhode Island's Medicaid Section 1115 demonstration waiver provide the necessary authorities for the health care administered through the Medicaid program and establish the respective roles and responsibilities of beneficiaries, providers, and the State.

Additionally, EOHHS possesses, among others, the following duties and responsibilities:

~~Lead the state's four (4) health and human services departments in order to:~~

- ~~• Improve the economy, efficiency, coordination, and quality of health and human services policy and planning, budgeting and financing;~~
- ~~• Design strategies and implement best practices that foster service access, consumer safety and positive outcomes;~~
- ~~• Maximize and leverage funds from all available public and private sources, including federal financial participation, grants and awards;~~
- ~~• Increase public confidence by conducting independent reviews of health and human services issues in order to promote accountability and coordination across departments;~~
- ~~• Ensure that state health and human services policies and programs are responsive to changing consumer needs and to the network of community providers that deliver assistive services and supports on their behalf. (See Rhode Island General Laws section 42-7.2-2 et seq.).~~

The four state agencies under EOHHS ~~possess and~~ maintain the legal authority to execute their respective powers and duties in accordance with their statutory authority applicable laws except as otherwise provided in §42-7.2.

Unless otherwise noted, the "state agency" referenced herein means EOHHS.

~~October 2013~~

~~**Applicability.** The provisions in this section do not apply to the individuals and families in the Medicaid affordable care coverage (MACC) groups identified in MCAR section 1301 that take effect on January 1, 2014. The rule governing the application process for the Medicaid affordable coverage groups included in section 1301 are located in MCAR section 1303. **Accordingly, the provisions in this rule pertaining to individuals and families in the MACC groups outlined in section 1301 apply only to those who were enrolled and receiving Medicaid coverage prior to January 1, 2014, as specified.**~~

B. Purposes and Scope of the Medicaid Program

REV: ~~October 2013~~ June 2014

The Rhode Island Medicaid ~~Program~~ program is the joint federal/state health care program that provides publicly funded health coverage to low-income individuals and families, adults without dependent children age nineteen (19) to sixty-four (64), elders, and persons with disabilities who otherwise cannot afford or obtain the services and supports they need to live safe and healthy lives.

~~The Statutory foundations of the Rhode Island Medicaid Program are Title XIX of The Social Security Act, Rhode Island General Laws 40-8, and Rhode Island General Laws 42-7.2, as noted above.~~

(1) Eligibility -- Coverage Groups. A coverage group is a classification of individuals eligible to receive Medicaid benefits based on a shared characteristic such as age, income, health status, and level of need criteria. Pursuant to the authority provided under the Medicaid and CHIP state plans and the State's Section 1115 demonstration waiver, health coverage, services, and supports are available to individuals and families who meet the eligibility requirements for the following coverage groups:

(a) Medicaid Affordable Care Coverage (MACC) Groups – To implement the federal Affordable Care Act (ACA 2010), the federal government has assisted the states in building state-of-the-art eligibility systems with the capacity to evaluate whether a consumer qualifies for affordable coverage funded in whole or in part through Medicaid, tax credits, and/or other subsidies. To ensure these eligibility systems function in the most efficient and consumer friendly manner possible, a single income standard – Modified Adjusted Gross Income or “MAGI” – must be used to determine the eligibility of all applicants for affordable coverage without respect to payer – that is, including Medicaid. Accordingly, the federal government has eliminated distinctions in the financial criteria and standardized the eligibility requirements to the extent feasible for the Medicaid populations subject to the MAGI. This, in turn, made it possible for the states to reorganize the MAGI-eligible populations with similar characteristics into distinct, easily identifiable, Medicaid affordable care coverage groups. The Rhode Island MACC groups are as follows:

(i) Families with children including children and young adults, pregnant women, infants and parents/caretakers with income up to the levels sets forth in Section 1303;

(ii) Adults between the ages of nineteen (19) and sixty-four (64) without dependent children who are otherwise ineligible for Medicaid and meet the income limits set forth Section 1303, including any persons in this age group who are awaiting a determination of eligibility for Medicaid for persons who are aged, blind, or living with disabilities pursuant to Sections 0356 and 0376 or Supplemental Security Income (SSI) pursuant to Section 0394;

(b) Integrated Health Care Coverage (IHCC) Groups – All applicants for Medicaid who must meet both clinical and financial eligibility requirements or who are eligible based on their participation in another needs-based, federally funded health and human services program are not subject to the MAGI. The State has reclassified these categorically and medically needy populations into coverage groups based on shared eligibility characteristics, level of need, and/or access to integrated care options as follows:

(i) Adults between the ages the ages of nineteen (19) and sixty-four (64) who are blind or disabled and elders age sixty-five (65) and older who meet the financial and clinical eligibility for Medicaid-funded coverage established pursuant to Section 0352;

(ii) Persons of any age who require long-term services and supports in an institutional or home and community-based setting who meet the financial and clinical criteria established pursuant to Section 0376 or in the case of children eligible under the Katie Beckett provision, who meet the criteria in Section 0394.35;

(iii) Individuals eligible for Medicaid-funded health coverage on the basis of their participation in another publicly funded program including children and young adults receiving services authorized by the Department of Children, Youth and Families and persons of any age who are eligible on the basis of receipt of SSI benefits.

(iv) Medically needy individuals who meet all the eligibility criteria for coverage in subparagraph (b)(i) or (ii) above except for excess income. Individuals in this coverage group achieve eligibility by applying a flexible test of income which applies excess income to certain allowable medical expenses thereby enabling the individual to “spend down” to within a medically needy income limit (MNIL) established by the Medicaid agency.

(v) Low-income elders and persons with disabilities who qualify for the Medicare Premium Payment Program (MPPP) authorized by the Title XIX. Medicaid pays the Medicare Part A and/or Part B premiums for MPPP beneficiaries.

(2) **Benefits.** Medicaid beneficiaries are eligible for the full scope of services and supports authorized by the Medicaid State Plan and the Section 1115 demonstration waiver.

(a) *General scope of coverage.* Although there is variation in benefits by coverage group, in general Medicaid health coverage includes the following:

<ul style="list-style-type: none">• <u>Doctor’s office visits</u>• <u>Immunizations</u>• <u>Prescription and over-the-counter medications</u>• <u>Lab tests</u>• <u>Residential treatment</u>• <u>Behavioral health services</u>• <u>Drug or alcohol treatment</u>• <u>Early and Periodic, Screening, Detection and Treatment (EPSDT)*</u>• <u>Referral to specialists</u>• <u>Hospital care</u>• <u>Emergency care</u>• <u>Urgent Care</u>• <u>Long-term Services and Supports (LTSS) in home and community-based and health care institution settings such as nursing homes</u>	<ul style="list-style-type: none">• <u>Home health care</u>• <u>Skilled nursing care</u>• <u>Nutrition services</u>• <u>Interpreter services</u>• <u>Childbirth education programs</u>• <u>Prenatal and post-partum care</u>• <u>Parenting classes</u>• <u>Smoking cessation programs</u>• <u>Transportation services</u>• <u>Dental care</u>• <u>Expedited LTSS</u>• <u>Organ transplants</u>• <u>Durable Medical Equipment</u>
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(b) *EPSDT.* Title XIX authorizes Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for all Medicaid beneficiaries who are under age twenty-one (21) for the purposes of identifying and treating behavioral health illnesses and conditions. Medically necessary EPSDT services must be provided irrespective of whether they are within the scope of Medicaid State Plan covered services.

(c) *Limits.* Certain benefits covered by the Medicaid State Plan or the State’s Section 1115 waiver are subject to limits under federal and/or State law. Program-wide benefit limits are set forth in section 0300.10(D) of this rule. Limits and restrictions applicable to specific coverage groups are located in the rules describing the coverage group and service delivery.

0300.10-01 C. Program Administration

REV: ~~October 2013~~ June 2014

(1) **Applications and Eligibility.** The EOHHS implements a “no wrong door” policy to ensure persons seeking eligibility for Medicaid health care coverage have the option to apply at multiple locations throughout the State and in a manner that is best suited to their needs including, but not limited to, in-person, on-line, by telephone, or by U.S. mail. Application and eligibility information for the MACC groups is located in MCAR Section 1303. An overview of the application process for the IHCC groups is located section 0302.

(a) *Determinations.* The EOHHS must make timely and efficient eligibility, enrollment, and renewal decisions. Accordingly, the EOHHS or an entity designated by the secretary for such purposes must review and make eligibility and renewal determinations for Medicaid health care coverage in accordance with applicable State and federal laws, rules, and regulations.

(b) *Timeliness.* In general, determinations must be made in no more than thirty (30) days from the date a completed application is received by the EOHHS or its designee unless clinical eligibility factors must be considered. In instances in which both clinical and financial eligibility factors are material to the application process, as for eligibility for Medicaid-funded LTSS or coverage for persons with disabilities, determinations must be made in ninety (90) days. Applicable time-limits and other eligibility requirements are set forth in the Medicaid Code of Administrative Rules in the sections and chapters related to each population Medicaid serves by eligibility coverage groups.

(c) *Cooperation.* As a condition of eligibility, the Medicaid 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 or termination of eligibility.

(2) **Eligibility Agent -- DHS.** The Medicaid State Agency is authorized under Title XIX and federal implementing regulations to enter into agreements with other State agencies for the purposes of determining Medicaid eligibility. The EOHHS has entered into a cooperative agreement with the Rhode Island Department of Human Services (DHS) that authorizes the DHS to conduct certain eligibility functions. In accordance with the Code of Federal Regulations (CFR) at 42§ 431.10 (e)(3), the DHS has agreed to carry out these functions in accordance with the Medicaid State Plan, the

State's Section 1115 demonstration waiver, and the rules promulgated by the EOHHS.

(3) **Written Notice.** The executive office is responsible for notifying an applicant, in writing, of an eligibility determination. If eligibility has been denied, the notice to the applicant sets forth the reasons for the denial along with the applicable legal citations and the right to appeal and request a fair hearing. Section 0110 describes in greater detail the appeal and hearing process.

(4) **Mandatory Managed Care Service Delivery.** To ensure that all Medicaid beneficiaries have access to quality and affordable health care, the EOHHS is authorized to implement mandatory managed care delivery systems. Managed care is a health care delivery system that integrates an efficient financing mechanism with quality service delivery, provides a medical home to assure appropriate care and deter unnecessary services, and places emphasis on preventive and primary care. Managed care systems also include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the Medicaid agency. Managed care systems include the Medicaid program's integrated care options such as long-term services and supports and primary care health coverage for eligible beneficiaries. The managed care options for Medicaid beneficiaries vary on the basis of eligibility as follows:

- (a) Families with children eligible under Section 1305 are enrolled in a RIt Care managed care plan in accordance with Section 1310 or, as applicable, an employer health plan approved by the executive office for the RIt Share premium assistance program in accordance with Section 1312 unless specifically exempted;
- (b) Adults ages nineteen (19) to sixty-four (64) eligible in accordance with Section 1305 are enrolled in a Rhody Health Partners managed care plan in accordance with Section 1309 or, as applicable, an employer health plan approved by the executive office for the RIt Share premium assistance program in accordance with Section 1312 unless specifically exempted;
- (c) Elders and adults who are blind or living with a disability and between the ages of nineteen (19) and sixty-four (64) eligible pursuant to Section 0352 are enrolled in a Rhody Health Partners plan or Connect Care Choice primary care case management practices in accordance with Section 0374 and/or 0375.
- (d) Persons eligible for Medicaid-funded long-term services and supports in accordance with Sections 0376 *et seq.* have the choice of self-directed care, fee-for-service or enrolling for services in PACE, Rhody Health Options, or Connect Care Choice Community Partners in accordance with Section 0375.
- (e) Persons eligible as medically needy or as a result of participation in another publicly funded health and human services program may be enrolled in fee-for-service or a managed care plan depending on the basis of eligibility. See exemptions in Sections 1310, 1312, and 0374-0375 related to coverage group.

(5) **Waiver eligibility and services.** Until 2009, the Medicaid program utilized authorities provided through its RIt Care Section 1115 and multiple Title 1915(c) waivers to expand eligibility and access to benefits beyond the scope provided for in the Medicaid State Plan. At that time, the State received approval from the Secretary of the U.S. Department of Health and Human Services (DHHS)

to operate the Rhode Island Medicaid program under a single Section 1115 demonstration waiver. All Medicaid existing Section 1115 and Section 1915(c) waiver authorities have been incorporated into the Medicaid program-wide Section 1115 demonstration waiver, as it has been renewed and extended, since it was initially approved in 2009.

The Rhode Island Executive Office of Health and Human Services (EOHHS) is the agency of state government legally designated as the Medicaid single state agency. In this capacity as, the EOHHS is responsible for administering the organization, financing, and delivery of Medicaid.

0300.15.10 Medically Needy

REV: October 2013

The Medically Needy are those individuals or families whose resources and/or income exceed the standards required for eligibility, but are within the Medically Needy standards. Applicants may achieve Medically Needy eligibility with a Flexible Test of Income which applies excess income to certain allowable medical expenses, enabling individuals or families to spend down to within Medically Needy income limits. In addition to meeting the income and resources criteria, Medically Needy recipients must also meet all non-financial requirements for Medicaid eligibility.

0300.20 Scope of Services

REV: October 2013

Medicaid recipients other than those who qualify as Medically Needy are entitled to the full scope of medical services provided by the Medicaid Program.

Recipients eligible as Medical Needy are entitled to a limited scope of medical services.

0300.20.05 Medical Services Provided

REV: October 2013

The medical services provided are:

MEDICAL SERVICES PROVIDED

<i>Service</i>	<i>Not Medically Needy</i>	<i>Medically Needy</i>
Inpatient Hospital Services	Yes 1,2	Yes 1,2 (see note below)
Inpatient Psychiatric Hospital	Yes	Yes Services for those age 65 and over or under age 21
Outpatient Hospital Services:	(see note below)	
Clinic and Emergency Room	Yes 1,3	No
Laboratory and X-rays	Yes	Yes
Physician Services	Yes 1,2	Yes 1,2
Pharmacy Services	Yes 8, 9, 10	Yes 8, 9, 10
Dental Services	Yes	Yes
Clinical Laboratory Services	Yes	Yes
Durable Medical Equipment, Appliances, and Prosthetic Devices	Yes	Yes 4 Surgical
Certified Home Health	Yes	Yes Services

<i>Service</i>	<i>Not Medically Needy</i>	<i>Medically Needy</i>
Agency		
Podiatry Services	Yes	No
Ambulance Services	Yes	Yes
Community Mental Health Center	Yes	Yes Services
Substance Abuse Services	Yes 5	Yes 5
Nursing Facility Services	Yes	Yes
Optometric Services	Yes 6	Yes 7
Intermediate Care Facility and Services for the Mentally Retarded	Yes	Yes Day Treatment

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 Medicaid 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 the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (DBHDDH).
6. For recipients age 21 and older, the following optometry services are limited to once every two years:
 - a. one refractive eye care exam;
 - b. one pair of eyeglasses (frames, lenses, dispensing fees).
7. For recipients age 21 and older, payment will be made for one refractive eye care 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.
9. Rhode Island Medicaid utilizes a preferred drug list.

If an individual requires a drug that is not listed on the preferred drug list, it is necessary for the individual to obtain prior approval from EOHHS. Procedures for submitting a request for prior approval authorizations are delineated in the Medicaid Provider Manual located on the EOHHS website at www.eohhs.ri.gov. Denials of a prior authorization are subject to the appeal process as stated in the General Provisions, Section 0110 of the DHS and Section 0110 of the EOHHS Rules.

0300.20.05.10 EPSDT

REV: October 2013

Title XIX of the Social Security Act provides for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of eligible Medicaid 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 MEDICAID SCOPE OF SERVICES. Eligible individuals under age 21 receive Medicaid services consistent with EPSDT requirements.~~

0300.20.05.15 Abortions, Rape, or Incest

REV: October 2013

~~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 Medicaid Program:~~

- ~~• 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.~~
- ~~• 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.~~
- ~~• The statements must be kept in the medical record for a period of three years to maintain an audit trail.~~
- ~~• 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: October 2013

~~Payment for an abortion will be rendered when a physician has found, and certified in writing to the EOHHS 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 Medicaid 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 Medicaid payment for services, the physician must:~~

- ~~• Be a doctor of medicine or osteopathy who is licensed to practice in the State of Rhode Island;~~
- ~~• Determine and certify in writing that in his/her professional judgment, the abortion was medically necessary to save the life of the mother;~~
- ~~• Retain a copy of the certification in the patient's medical record for a period of three years for purposes of audit;~~
- ~~• 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: October 2013

ORGAN TRANSPLANT OPERATIONS

~~The following organ transplant operations are provided as Medicaid 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 Secretary of the Executive Office of Health and 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 Secretary 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 Medicaid Program Provider Reference Manual.~~

D. Program-wide Limits and Restrictions

Both federal and State law impose certain limits and restrictions on the scope, amount, and duration of the health care coverage, services, and supports financed and administered through the Medicaid program.

(1) Benefits authorized under the Medicaid State Plan and the State's Sections 1115 demonstration waiver are limited as follows:

- (a) **Termination of pregnancy.** The deliberate termination of a pregnancy – or an abortion – is only a paid Medicaid service when the pregnancy is the result of an act of rape or incest or the termination is necessary to preserve the life of the woman. The treating physician performing the procedure must submit to EOHHS along with a request for payment a sworn, written statement certifying that: (1) the woman's pregnancy was the result of rape or incest or (2) the termination was necessary to save the life of the mother. A copy of this letter must be maintained in the woman's patient record for a period of no less than three (3) years. In cases

of rape or incest, the woman receiving the termination procedure must also submit a sworn statement to EOHHS attesting that her pregnancy was the result of rape or incest. This requirement may be waived if a treating physician certifies that the woman is unable for physical or psychological reasons to comply. The procedure must be performed by a Rhode Island licensed physician in an appropriately licensed hospital-setting or out-patient facility.

(b) Organ Transplant Operations. Medicaid provides coverage for organ transplant operations deemed to be medically necessary upon prior approval by the EOHHS.

(i) Medical necessity for an organ transplant operation is determined on a case-by-case basis upon consideration of the 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.

(ii) Prior Written Approval of the Secretary or his/her designee is required for all covered organ transplant operations. Procedures for submitting a request for prior approval authorizations are available through the provider portal on the EOHHS website at: www.eohhs.ri.gov/providers.

(iii) Authorized Transplant Operations provided as Medicaid services, upon prior approval, when certified by a medical specialist as medically necessary and proper evaluation is completed, as indicated, by the transplant facility are as follows:

- Certification by medical specialist required -- kidney transplants, liver transplants, cornea transplants, and bone marrow transplants.
- Certification by an appropriate medical specialist and evaluation at the transplant facility - pancreas transplants, lung transplants, heart transplants, heart/lung transplant.

(iv) Other Organ Transplant Operations as may be designated by the Secretary of the Executive Office of Health and Human Services after consultation with medical advisory staff or medical consultants.

(c) Pharmacy Services for Dual Eligible Beneficiaries. Under federal law, states providing a Medicaid-funded pharmacy benefit must extend or restrict coverage and co-pays to beneficiaries eligible for both Medicaid and Medicare as follows:

REV: 09/2006

(i) Medicare Part D Wrap. ~~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~~ Medicare-approved prescription drug plan. Therefore, Medicaid these dually eligible Medicaid-Medicare beneficiaries who also receive Medicare benefits do not receive are not eligible for the Medicaid pharmacy benefits under the State Medicaid Program. There are, however, ~~six (6)~~ six (6) certain classes of drugs that are ~~exempted from these drug plans~~ not covered by Medicare Part D plans. ~~and for which Medicaid will~~

provide coverage under Medicaid Pharmacy Services is available to those receiving Medicare for these classes of drugs. The ~~six (6)~~ classes of drugs covered by Medicaid are: barbiturates, benzodiazepines, vitamins and minerals (with the exception of prenatal vitamins and fluoride treatment), Medicaid-approved over-the-counter medications, ~~and~~ cough and cold medications, smoking cessation medications, and covered weight loss medications (with prior authorization). When purchasing these ~~six (6)~~ classes of drugs, Medicaid beneficiaries are required to pay a co-payment of one dollar (\$1.00) for generic drug and three dollars (\$3.00) for a brand name drug prescription.

0300.20.05.35.05 Pharmacy Services Cost Sharing Requirements

REV: 1/2014

(ii) Medicare Part D Cost-sharing Exemption. Section 3309 of the Affordable Care Act amends section 1860D-14 (a)(1)(D)(i) of the Social Security Act (the Act) to extend elimination of There is no Medicare Part D cost-sharing to for full benefit Medicaid-Medicare dual eligible individuals beneficiaries who would be institutionalized if they require the level of services provided in a long-term health facility if they were not receiving Medicaid-funded home and community-based services under a home and community based waiver authorized by a State under section 1115, or subsections (c) or (d) of section 1915, or under a State plan amendment under section 1915(i), Title XIX waiver authority, the Medicaid State Plan, or if such services are provided through enrollment in a Medicaid managed care organization with a contract under section 1903(m) or under section 1932. To obtain the cost-sharing exemption, the Medicare Part D plan sponsor must receive proof of participation in one of the following Medicaid-funded home and community-based services programs:~~Home and Community Based Services includes the following programs:~~ Preventive/Core Services, Personal Choice, Habilitation, Shared Living, and Assisted Living and as well as the co-pay program administered by the Division of Elderly Affairs (DEA). ~~Programs~~all dual eligible beneficiaries receiving Home and Community Based Services (HCBS) such home and community based services must provide evidence of receipt of HCBS to their Part D plan sponsor. ~~Home and Community Based Services includes the following programs:~~ Preventive, Core Services, Personal Choice, Habilitation, Shared Living, Assisted Living and Division of Elderly Affairs (DEA) Programs.

0300.20.20 Waiver Programs

REV: October 2013

The Rhode Island EOHHS operates several programs under the 1115 Research and Demonstration Waivers. The 1115 Waiver allows beneficiaries to obtain the Medicaid services they need in the most appropriate least restrictive setting. The types of long term care available to beneficiaries are categorized as institutional and home and community based. To be eligible, a recipient must require the level of care provided in an institutional setting, and meet the eligibility criteria described in the specific Long Term Services and Supports program.

0300.20.25 Medicaid Payment Policy

REV: October 2013

Medicaid 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 Medicaid 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 Medicaid 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: October 2013

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 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:

- **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 Medicaid agency.
- **Intermediate Care Facilities/Mental Retardation (ICF/MR)** Reports are sent to the Central Office of the Medicaid agency. The agency is required to send the reports for both Nursing and Intermediate Care Facilities/Mental Retardation to the appropriate Long Term Services and Supports (LTSS) Unit covering the district in which the facility is located. The agency must also send the ICF/MR 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 Services and Supports (LTSS) 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 Premium Assistance Program

REV: October 2013

The Medicare Premium Assistance Program is a provision of the Medicaid program which allows Medicaid to pay for the Medicare Part A and/or Part B premiums of certain categories of Medicaid eligibles.

0300.20.40 Pharmacy Lock-In Program

REV: October 2013

(2) Federal law and regulations The Code of Federal Regulations (CFR) at 42 CFR sec. 440.230(d) allows authorize the Medicaid agency, or its contracted Managed Care Organization(s) or its authorized contractual agent (managed care plan/organization) to place appropriate limits restrictions on a Medicaid-funded benefit or service on a medical service based on such criteria as medical necessity or on utilization control procedures (42 CFR§ 440.230(d)). The Medicaid Pharmacy Lock-In Program has been was established by the Medicaid agency under this authority to restrict recipients whose access to full pharmacy services in instances in which there is documented excessive use by a beneficiary utilization of medical services is documented as being excessive.

Recipients Beneficiaries are "Locked-In" to specific providers in order to monitor services received and reduce unnecessary or inappropriate utilization. This program is intended to prevent Medicaid recipients beneficiaries from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

0300.20.40.05 (a) Enrollment. in Pharmacy Lock-In Program. REV: October 2013

Whenever Medicaid records indicate that recipient beneficiary utilization is excessive or inappropriate ~~with reference given actual~~ to medical need, the Medicaid agency or its authorized contractual agent, ~~or its contracted Managed Care Organization(s)~~, may require an individual to designate a physician and pharmacy of choice for exclusive service ~~in order to~~:

- Protect the individual's health and safety;
- Provide continuity of medical care;
- Avoid duplication of service by providers;
- Avoid inappropriate or unnecessary utilization of Medicaid as defined by community practices and standards; and
- Avoid excessive utilization of prescription medications.

The determination of whether utilization is "excessive" must be based on current evidence-based practices and appropriate Excessive utilization of prescription medications will be determined from ~~published current~~ medical and pharmacological references. ~~The Medicaid agency or its contracted Managed Care Organization(s) selects for enrollment in the Medicaid Pharmacy Lock-In Program recipients who have a documented history of obtaining excessive or inappropriate prescribed drugs under the Medicaid Program. Recipients~~

(b) Notice. Beneficiaries determined to have excessive utilization are provided with will be given a written notice (MA/DUR-1 or similar notice from the specific health plan) of his/her excessive or inappropriate utilization at least thirty (30) days prior to the implementation imposition of the pharmacy lock-in restriction. Upon notification, beneficiaries and will be are asked to choose a primary pharmacy/physician as a single source of medical for all Medicaid health care. The notification will also advise the individual beneficiary that failure to cooperate ~~in this program~~ will necessitate result in the Medicaid agency's designating a physician/pharmacy ~~for the individual based on the recipient's previous use and geographical location~~ to serve in this capacity based on other factors such utilization patterns and location. The notification will include the individual's includes a statement of the right to request a fair hearing within thirty (30) days if ~~he/she~~ the beneficiary disagrees with the findings and the Medicaid agency's action.

0300.20.40.10 REVS Identification of Lock-In Recipients

REV: October 2013

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

0300.20.40.15 (3) Primary Pharmacy of Choice

REV: ~~October 2013~~ June 2014

The Primary Pharmacy of Choice must monitor the drug utilization of each restricted recipient and must exercise sound professional judgment 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 EOHHS or its contracted Managed Care Organization(s), including the recovery of payments.

0300.20.40.20 (4) Primary Care Physician

REV: ~~05/1995~~ June 2014

(a) 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: ~~October 2013~~

(b) A recipient may change his/her primary pharmacy/physician for reasonable cause by notifying the Medicaid Pharmacy Lock-In Program or its contracted Managed Care Organization(s) and choosing a new primary pharmacy/physician.

0300.20.40.30 (5) Change in Recipient Status

REV: ~~October 2013~~ June 2014

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

0300.25 Overview of Medicaid Eligibility Requirements

REV: ~~October 2013~~

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

0300.25.05 Technical Eligibility Requirements

REV: ~~October 2013~~

~~Technical eligibility requirements for the Rhode Island Medicaid Program are citizenship, residence and possession of, or application for, a Social Security number.~~

~~Effective July 1, 2006, in conformance with the federal Deficit Reduction Act of 2005, both applicants and recipients for Medicaid are required to verify both citizenship and identity at the time of application for benefits or redetermination, if not previously verified.~~

~~To reduce barriers to eligibility for Medicaid Program applicants/recipients, the Medicaid agency will attempt to verify citizenship and identity via the State Verification and Exchange System (SVES) interface with the Social Security Administration. If the interface reveals a discrepancy or is unable to~~

~~provide verification of citizenship or identity, it is the responsibility of the applicant/recipient to provide the required verification as detailed in Section 0304.05.10.05.~~

~~Applicants who do not comply with the requirement to verify both citizenship and identity will be denied Medicaid benefits. Recipients who do not comply with the requirement to verify both citizenship and identity will have their Medicaid benefits terminated.~~

~~0300.25.10 Characteristic Eligibility Requirements~~

~~REV: October 2013~~

~~Characteristics are non-financial eligibility factors. The required characteristics for an individual applying for Medicaid are those of the SSI program—age (65 or older), blindness or disability. For all other individuals and families, see sections 1301, 1303, and 1305 MCAR.~~

~~0300.25.15-01.E Cooperation Requirements~~

~~REV: October 2013 June 2014~~

~~As a condition of eligibility, the Medicaid 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: October 2013~~

~~Medicaid policy provides that an otherwise eligible applicant with income in excess of the allowable income limits may be eligible for Medicaid 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 spend down in which allowable medical expenses absorb his excess income, enabling him to qualify for Medicaid as Medically Needy.~~

~~0300.30 Methodology for Determining Coverage Group~~

~~REV: October 2013~~

~~A Coverage Group is a classification of individuals eligible to receive Medicaid benefits. There are numerous coverage groups distinguishable by income and resource standards and other nonfinancial criteria. An individual must satisfy all the requirements of at least one coverage group to be eligible for Medicaid. Medicaid 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 Medicaid 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 Medicaid 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 Medicaid coverage groups. Thus, if family members meet the required characteristics of Medicaid 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 Medicaid 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 Medicaid 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 Medicaid applicant may belong, usually based on the non financial criteria of the coverage groups. Medicaid 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 Medicaid 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.

0300.40 Procedure for Imposing Administrative Sanctions

0300.40.05 Statutory Authority

REV: October 2013

In accordance with Title 42 Chapter 35 of the General Laws of Rhode Island (The Administrative Procedures Act), Title 40 Chapter 8.2, the Rhode Island EOHHS hereby establishes administrative procedures to impose sanctions on providers of medical services and supplies for any violation of the rules, regulations, standards or laws governing the Rhode Island Medicaid Program. The Federal Government mandates the development of these administrative procedures for the Title XIX Medicaid Program in order to insure compliance with Sections 1128 and 1128A of the Social Security Act, which provides for federal penalties to be imposed for activities prescribed therein.

0300.40.10 Definitions

REV: October 2013

As used hereafter, the following terms and phrases shall, unless the context clearly required otherwise, have the following meanings:

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (U.S. Public Law 111-148); and the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-152), as amended.

Dual eligibles means Medicare beneficiaries who have limited income and resources who may get help paying for their out-of-pocket medical expenses from the state Medicaid program. For people who are eligible for full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under the state Medicaid program. Services that are covered by both programs will be paid first by Medicare and the difference by Medicaid, up to the state's payment limit.

Provider—any individual, firm, corporation, association, institution or group qualified or purporting to be qualified to perform and provide the medical services and supplies, which are within the scope of the services covered by the Rhode Island Medicaid Program.

~~**Rhode Island Medicaid Program**—established on July 1, 1966, under the provisions of Title XIX of the Social Security Act, as amended (P. L. 89-97). The enabling State Legislation is to be found at Title 40, Chapter 8 of the Rhode Island General Laws, as amended.~~

~~**Secretary** means the Rhode Island Secretary of the Executive Office of Health and Human Services who is responsible for the oversight, coordination, and cohesive direction of state administered health and human services, including the Medicaid agency, and for ensuring all applicable laws are executed.~~

~~**State Agency** means the Rhode Island Executive Office of Health and Human Services (EOHHS) which is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Title XIX Medicaid Program.~~

~~**State Health Care Program**—includes but not limited to those programs defined in section 1128 (h) of the Act such as those totally state funded and administered by the Department.~~

~~**Statutory Prerequisites**—any license, certificate or other requirement of Rhode Island law or regulation which a provider must have in full force and effect in order to qualify under the laws of the State of Rhode Island to perform or provide medical services or to furnish supplies. The prerequisites include but are not limited to, licensure by the Rhode Island Department of Health, the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (DBHDDH), certification for participation in the Federal Medicare Title XVIII Program and any other legal requirement pertinent to the delivery of the specific medical services and supplies. The term statutory prerequisite includes any requirement imposed by this Department through duly promulgated administrative regulations.~~

~~**0300.40.15 Sanctionable Violations**~~

~~REV: October 2013~~

~~All providers of medical services and supplies are subject to the general laws of the State of Rhode Island and the rules and regulations governing the Rhode Island Medicaid Program. Sanctions may be imposed by the Department against a provider for any one (1) or more of the following violations of applicable law, rule or regulation:~~

- ~~(i) Presenting or causing to be presented for payment any false or fraudulent claim for medical services or supplies.~~
- ~~(ii) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than to which the provider is legally entitled.~~
- ~~(iii) Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.~~
- ~~(iv) Failure to disclose or make available to the Single State Agency or its authorized agent records of services provided to Medicaid recipients and records of payments made for such services.~~
- ~~(v) Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as determined by an official body of peers.~~
- ~~(vi) Engaging in a course of conduct or performing an act deemed improper or abusive of the Medicaid Program or continuing such conduct following notification that said conduct should cease.~~
- ~~(vii) Breach of the terms of a Medicaid provider agreement or failure to comply with the terms of the provider certification of the Medicaid claim form.~~
- ~~(viii) Over-utilizing the Medicaid Program by inducing, furnishing or otherwise causing a recipient to receive services or supplies not otherwise required or requested by the recipient.~~
- ~~(ix) Rebating or accepting a fee or portion of a fee or charge for a Medicaid recipient referral.~~
- ~~(x) Violating any provisions of applicable Federal and State laws, regulations, plans or any rule or regulation promulgated pursuant thereto.~~
- ~~(xi) Submission of false or fraudulent information in order to obtain provider status.~~

- ~~(xii) Violations of any laws, regulations or Code of Ethics governing the conduct of occupations or professions or regulated industries.~~
- ~~(xiii) Conviction of a criminal offense for any intentional, reckless, or negligent practice resulting in death or injury to patients.~~
- ~~(xiv) Failure to meet standards required by State or Federal laws for participation such as licensure and certification.~~
- ~~(xv) Exclusion from the Federal Medicare Program or any state health care program administered by the Department because of fraudulent or abusive practices.~~
- ~~(xvi) A practice of charging recipients or anyone in their behalf for services over and above the payment made by the Medicaid Program, which represents full and total payment.~~
- ~~(xvii) Refusal to execute provider agreement when requested to do so.~~
- ~~(xviii) Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from the Single State Agency.~~
- ~~(xix) Formal reprimands or censure by an association of the provider's peers for unethical practices.~~
- ~~(xx) Suspension or termination from participation in another governmental medical program such as Workers' Compensation, Children With Special Health Care Needs Program, Rehabilitation Services, the Federal Medicare Program, or any state health care program administered by the Department.~~
- ~~(xxi) Indictment for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.~~
- ~~(xxii) Failure to repay or make arrangement for the repayment of identified overpayments or otherwise erroneous payments.~~

0300.40.20 Provider Sanctions

REV: October 2013

~~Any one (1) or more of the following sanctions may be imposed against providers who have committed any one (1) or more of the violations contained in Section 0300.40.15, above:~~

- ~~(i) Termination from participation in the Medicaid Program or any state health care program administered by EOHHS.~~
- ~~(ii) Suspension of participation in the Medicaid Program or any state health care program administered by EOHHS.~~
- ~~(iii) Suspension or withholding of payments.~~
- ~~(iv) Transfer to a closed end provider agreement not to exceed twelve (12) months or the shortening of an already existing closed end provider agreement.~~
- ~~(v) Prior authorization required before providing any covered medical service and/or covered medical supplies.~~
- ~~(vi) Monetary penalties.~~
- ~~(vii) Prepayment audits will be established to review all claims prior to payment.~~
- ~~(viii) Initiate recovery procedures to recoup any identified overpayment.~~
- ~~(ix) Except where termination has been imposed a provider who has been sanctioned may be required to attend a provider education program as a condition of continued participation in any health care program administered by EOHHS. A provider education program will include instruction in: (a) claim form completion; (b) the use and format of provider manuals; (c) the use of procedure codes; (d) key provisions of the Medicaid Program; (e) reimbursement rates; and (f) how to inquire about procedure codes or billing problems.~~

0300.40.25 Notice of Violations and Sanctions

REV: October 2013

~~When the Medicaid agency is in receipt of information indicating that a provider has committed a violation, and that provider is formally suspended or terminated, it shall forward by registered mail a notice of such violation to the provider. The notice shall include the following:~~

- ~~(i) A short and plain statement of the facts or conduct, which are alleged to warrant the intended departmental action. If the Medicaid agency is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved and detailed statement shall be furnished.~~
- ~~(ii) A statement of the provider's right to a hearing and that such a hearing must be claimed within fifteen (15) days of the receipt of the notice.~~

~~0300.40.30 Informal Hearing~~

~~REV: October 2013~~

~~Within fifteen (15) days after the receipt of a notice of an alleged violation and a sanction, the provider may request an informal hearing with the Medicaid agency.~~

~~This informal hearing will provide an opportunity for the provider to discuss the issues and attempt to come to a mutually agreeable resolution, thereby obviating the need for a formal administrative hearing. Informal dispositions may also be made of any contested case by stipulation, consent order, or default.~~

~~0300.40.35 Administrative Hearing~~

~~REV: October 2013~~

~~The right to an administrative appeal is conditioned upon the appellant's compliance with the procedures contained in these regulations and the hearing will be held in compliance with the provisions of the State's Administrative Procedures Act, as found at RIGL 42-35, as amended, and in conformance with DHS and EOHHS Policy Section 0110 et al.~~

~~0300.40.40 Appeal for Judicial Review~~

~~REV: 08/2007~~

~~Any provider who disagrees with the decision entered by the Hearing Officer as a result of the Administrative Hearing has a right to appeal for judicial review of the Hearing decision by filing a complaint with the Superior Court within thirty (30) days of the date of the decision in accordance with RIGL 42-35-15.~~

~~0300.40.45 Administrative Actions~~

~~REV: October 2013~~

~~Once a sanction is duly imposed on a provider, EOHHS shall notify the Rhode Island Department of Health (the licensing agent) and the Federal Medicare Title XVIII program if appropriate, state health care programs as defined in Section 1128(h) of the Social Security Act (as amended), state-funded health care programs administered by the Medicaid agency, or any other public or private agencies involved in the issuance of a license, certificate, permit or statutory prerequisite for the delivery of the medical services or supplies. Furthermore, EOHHS shall notify all affected Medicaid recipients.~~

~~0300.40.50 Stay of Order~~

~~REV: 08/2007~~

~~Orders may be stayed in accordance with RIGL 42-35-15 and 40-8.2-17.~~

~~0300.40.55 Reinstatement~~

~~REV: October 2013~~

- ~~(i) Pursuant to 42 CFR 1002.214 Subpart C, a state may afford a reinstatement opportunity to a state-initiated termination or suspension of any individual or entity. Such individuals or entities may be reinstated to the Medicaid Program only by EOHHS. The sanctioned individual or entity may submit a request for reinstatement to EOHHS at any time after the date specified in the notice of termination or suspension.~~

- (ii) ~~EOHHS may grant reinstatement only if it is reasonably certain that the types of actions that formed the basis for the original exclusion have not recurred and will not recur. Factors EOHHS will consider in making such a determination are contained in 42 CFR 1002.215(a)(1)(2)(3) Subpart C.~~
- (iii) ~~If EOHHS approves the request for reinstatement, it will provide the proper notification to the excluded party and all others in accordance with 42 CFR 1002.212 Subpart C. If EOHHS does not approve the request for reinstatement, it will notify the excluded party of its decision. Any appeal of a denial of reinstatement will be in accordance with state procedures and not subject to administrative or judicial review.~~

~~0300.45 Expedited Services~~

~~0300.45.05 Expedited Services Provision for Home And Community Based Services (H.C.B.S.)~~ ~~REV: October 2013~~

~~Section 40-8.9-4 of the Rhode Island General Laws was amended in June 2007 to require the Medicaid agency to establish criteria for the purpose of accessing home and community care effective January 1, 2008. The funding for this mandate is from the added dollars realized from the cost savings from reductions in the number of nursing facility bed days from those projected to be used annually (including bed days used for persons utilizing the hospice benefit).~~

~~The Medicaid agency has instituted an Expedited Services provision in order to enable the temporary provision of specified Home and Community Based Services (HCBS) to those entrants to the publicly financed Long Term Services and Supports system who meet certain criteria and requirements, and who are deemed likely to be successful in their application for Long Term Services and Supports (LTSS) Medicaid.~~

~~Persons who are already in receipt of HCBS are not eligible for this Expedited Services provision. Receipt of LTSS Medicaid, Title XX home care services, D.E.A. home care services, P.A.C.E., Medicare home care services, Visiting Nurse services, etc. are disqualifiers for the authorization of Expedited Services.~~

~~If there is a recognized Third Party Liability (TPL) opportunity, then the applicant is not eligible for Expedited Services. Trained and certified home and community-based service providers will be reimbursed for the provision of these Expedited Services to individuals who are pending a determination of LTSS Medicaid eligibility, ONLY IF that provider, and the individual they refer, successfully meet the requirements set forth in the following sections.~~

~~The HCBS services which are covered under this provision are authorized for up to twenty one (21) days, and up to ten (10) hours weekly. Some subsequent extension may be possible after a review of the case. The Adult Day Care services which are covered under this provision are authorized for up to twenty one (21) days, and up to three (3) days weekly. Some subsequent extension may be possible after a review of a case.~~

~~Payment for the HCBS so provided will cease upon the determination of the applicant's eligibility for Long Term Services and Supports Medicaid, or upon the twenty first (21st) day of Expedited Services, whichever comes first. It is possible that in cases of pending applications, Expedited Services may be extended beyond the initial twenty one (21) days. Successful LTSS Medicaid applicants will be transitioned onto the HCBS waiver program. Applicants who are denied LTSS Medicaid will immediately cease to be eligible for Medicaid agency payment for their Expedited Services.~~

~~Whenever the applicant is determined to be eligible for LTSS Medicaid, the expense incurred by the state for their HCBS under this provision will be submitted for standard Medicaid re-imburement, back to the date of LTSS Medicaid eligibility.~~

~~It is important to note that this is NOT a determination of LTSS Medicaid eligibility. What is being determined is only whether the requirements for Expedited Services are met.~~

Applicants may be found eligible for Expedited Services, but subsequently be determined ineligible for LTSS Medicaid. (The reverse is also possible).

Note: Individuals may submit applications for Medicaid at any time during the month of application.

0300.45.10 Home & Community Based Services Covered

REV: October 2013

Persons who are already covered by LTSS Medicaid are NOT eligible for these Expedited Services. ONLY individuals who need to file a new application to obtain LTSS Medicaid can qualify for the provision of Expedited Services.

The services that are guaranteed temporary payment under this provision are:

1. Assistance to the applicant in obtaining, completing, and submitting a COMPLETE LTSS Medicaid application and supporting financial and medical documentation as specified by the R.I. DHS and EOHHS. Additionally, all the Expedited Service forms must be complete and submitted at the same time. Payment for this assistance is at a capped rate, established by the R.I. EOHHS.

~~NOTE: THE SERVICE OF ASSISTING WITH a new LTSS/Medicaid APPLICATION IS A PREREQUISITE FOR THE AUTHORIZATION OF ANY EXPEDITED SERVICE.~~

2. Homemaking services provided by a home health agency licensed to practice in Rhode Island at the established Medicaid rate.
3. Personal Care services provided by a home health agency licensed to practice in Rhode Island at the established Medicaid rate.
4. Adult Day Care services provided by a licensed Adult Day Care Provider at the established Medicaid rate.

0300.45.15 Provision for Receiving Expedited Services

REV: January 2014

Trained and certified providers will be reimbursed for these Expedited Services while a decision on the LTSS Medicaid application is pending under the following circumstances:

- I. The provider has assisted the individual in completing, signing, and submitting a COMPLETE LTSS Medicaid application with all required financial and medical documentation to the R.I. DHS and EOHHS.

The application and documentation submitted must include or indicate the following:

1. No transfers of assets within the past five (5) years;
2. The applicant's income is:
 - a. At or below one hundred percent (100%) of the Federal Poverty Level, or
 - b. At or under three (3) times the Federal Benefit rate (in Sec. 0362.05) and the individual signs a ~~DISCLAIMER AND AGREEMENT~~ form, in which they acknowledge and accept the limitations of Expedited Services, and agree that all of the applicant's countable income over one hundred percent (100%) of the Federal Poverty Level must be contributed on a monthly basis towards the cost of these Expedited Services. Or
 - c. ONLY for individuals who are 65 years of more of age, a third option is available: (if the applicant's income is) in excess of three (3) times the Federal Benefit Rate, and the individual signs a ~~DISCLAIMER and AGREEMENT FORM~~ in which they acknowledge and accept the limitations of Expedited Services, and agree that all of the applicant's countable income over the Medically Needy Income Limit (MNIL) for one (1) one (less allowable deductions) must be contributed on a monthly basis towards the cost of these Expedited Services. (The MNIL is found in Sec. 0330.05).
3. A signed ~~DISCLAIMER and AGREEMENT FORM~~ MUST be included with ALL referrals for Expedited Services (even if they will not have to make any co-payment) in order to document their understanding of the limits of Expedited Services.

4. ~~The bank statements and declared assets (excluding the primary residence, and one (1) car used for medical transportation) do not exceed \$4,000 for an individual or \$6,000 for a couple.~~
5. ~~Only one (1) real estate property, the primary residence, with no more than \$ 543,000.00 in equity value.~~
6. ~~The individual meets citizenship/registered alien Medicaid or State funded Medicaid criteria.~~
7. ~~The individual is a Rhode Island resident.~~
8. ~~The applicant meets a categorical requirement of age (65 years of age or older), blindness or disability or is applying for permanent and total disability status through the Social Security Administration or the MART.~~

~~If disability has not been determined by Social Security through S.S.I. or R.S.D.I., or by the R.I. DHS Medicaid Review Team (MART), the Disability Determination forms as specified on the Expedited Services forms MUST ALSO be completed and returned with the referral for Expedited Services.~~

~~H. The provider submits ALL the completed Expedited Services FORMS as specified by the state. The need for direct assistance, or supervision, in at least one Activity of Daily Living must be documented in the physician's form.~~

~~A Referral / Turn Around form must indicate which service(s) is/are being requested.~~

~~Reimbursement for services is available from the date approval is granted for Expedited Services by DHS based on satisfactory completion of established criteria.~~

~~NOTE: If any of the above requirements are incomplete or missing, Expedited Services are automatically denied.~~

~~0300.45.20 Requirements for Reimbursement~~

~~REV: October 2013~~

~~I. Certification of Providers of Expedited Services~~

~~The payment for the Expedited Services listed in Section 0300.45.10 is only available to providers who have successfully completed a state training on the items and procedures necessary for a successful:~~

1. ~~Long Term Services and Supports Medicaid application, and~~
2. ~~Request for Expedited Services.~~

~~Certification for providers will be on a time limited basis.~~

~~H. Reimbursement of the Provision of Expedited Services:~~

~~NOTE: PERSONS WHO ARE ALREADY IN RECEIPT OF ANY L.T.C. SERVICES (as specified in Sec. 0300.45.05) ARE NOT ELIGIBLE FOR THIS EXPEDITED SERVICES PROVISION. Reimbursement for the provision of Expedited Services, while the decision on the application for LTSS Medicaid is pending, is allowed in the following circumstances:~~

- A. ~~The provider has submitted to the state assigned staff a completed and signed Medicaid application with all required documentation as specified in 0300.45.15. These application materials MUST be received by the assigned state staff IN THE SAME MONTH THAT THE APPLICANT SIGNS the forms.~~
- B. ~~The provider must simultaneously submit to the state assigned staff ALL the COMPLETED forms required for Expedited Services, as specified by the state. These forms must document the need for direct assistance in at least one Activity of Daily Living or, the need for supervision by another person.~~
- C. ~~Payment is made for assistance in filing an application for LTSS Medicaid after the state's receipt of the completed LTSS Medicaid application, supporting documentation, and ALL fully completed Expedited Services forms. The service of assisting with a new LTSS/Medicaid application is a pre-requisite for the authorization of any Expedited Service.~~

~~NOTE: If in the course of assisting with the application, it becomes evident either:~~

1. ~~That the applicant is obviously ineligible, or~~

2. That the obtaining/preparation of the materials required to qualify for Expedited Services will delay the filing of the application for LTSS/Medicaid, then the provider is required to forward the signed application to the appropriate LTSS office. No payment for Expedited Service will be made for applicants who are obviously ineligible, nor will payment be authorized when fulfilling the requirements of the Expedited Service process results in a delay of filing the application.
- D. Reimbursement for the other Expedited Services is available from the date approval is granted for Expedited Services by the state, based on satisfactory completion of established criteria.
- III. R.I. Follow-Up Procedures**
- A. The state assigned staff receives the entire request for Expedited Services and:
1. Date stamps the application and notifies the provider within two (2) business days of receipt whether the referral / application are acceptable or not acceptable for Expedited Services.
 2. If the applicant is an SSI recipient, the state assigned staff confirms with the Office of Medical Review (OMR) whether or not they are active with Title XX services.
 3. Enters the Expedited Services beneficiary into the Stop Loss tracking system.
 4. If Expedited Services are denied, the assigned state staff notifies the provider using a Referral /Turn Around form.
- B. The state assigned staff then utilizes a transmittal sheet to forward the entire LTSS application, including the physician's assessment, to the appropriate LTSS office.
- C. Upon receipt of both the social worker's assessment and the physician's assessment, the Office of Medical Review is responsible for determining whether a Level of Care is met, following all established processes, and notifying the LTSS/AS/DEA worker assigned to the individual.
- D. If ONLY Adult Day Care Services (ADCS) is authorized under Expedited Services, those requesting ADCS only will also be forwarded to the appropriate LTSS office for review:
1. If it appears that such an individual has a need for HCBS waiver services, AND might qualify for a "Level of Care" (LOC), the application is processed as an LTSS/Medicaid waiver application.
 2. If that is not the case, then the LTSS office forwards all the received application materials to the appropriate state community Medicaid office, for the determination of eligibility according to the rules for Community based Medicaid.
- E. For the cases they retain, the Long Term Services and Supports Office is responsible for:
1. Determining eligibility for LTSS Medicaid, following all established processes;
 2. Forwarding appropriate cases to a DEA Case Management Agency for their usual development of an assessment, LOC, and creation of a case plan;
 3. Retaining other appropriate cases for processing as usual for A+D waiver; and
 4. Notifying the state assigned staff person.
- F. The state assigned staff person tracks all received applications for determinations and is responsible for authorizing Stop Loss payments, and removing payment authorizations under the Stop Loss provision at the time when eligibility determinations are made.

0302.30.10 F. Direct Reimbursement to Recipients Beneficiaries

REV: October 2013 June 2014

(1) Some individuals, while appealing a determination of Medicaid ineligibility, incur and pay for covered services. ~~To correct the inequitable situation which results from an erroneous determination made by the Medicaid agency, direct~~ Direct reimbursement is may be available to recipients beneficiaries in certain circumstances. Direct reimbursement is available to such individuals if, and only if, all of the following requirements are met:

1. A written request to appeal a denial or discontinuance of Medicaid coverage is received by the State within the time frame specified in Section 0110.20.
2. The original decision to deny or discontinue Medicaid coverage ~~is determined to be incorrect and, as such,~~ is reversed on appeal by the Appeals Officer (hearing decision) or by the Regional Manager or Chief Supervisor/Supervisor (adjustment conference decision).

Reimbursement is only available if the original decision was ~~incorrect~~ reversed. Reimbursement is not made, for example, if the original decision is reversed because information or documentation, not provided during the application period, is provided at the time of the appeal.

3. The recipient submits the following:

- A completed Application for Reimbursement form ~~(MA-1R)~~;
 - A copy of the medical provider's bill or a written statement from the provider which includes the date and type of service;
 - Proof of the date and amount of payment made to the provider by the recipient or a person legally responsible for the recipient. A cash receipt, a copy of a canceled check or bank debit statement, a copy of a paid medical bill, or a written statement from the medical provider may be used as proof of payment provided the document includes the date and amount of the payment and indicates that payment was made to the medical provider by the recipient or a person legally responsible for the recipient.
4. Payment for the medical service was made during the period between a denial of Medicaid eligibility and a successful appeal of that denial. That is, payment was made on or after the date of the written notice of denial (or the effective date of Medicaid termination, if later) and before the date of the written decision issued by the EOHHS Appeal Office, or decision by the Regional Manager/Chief Casework Supervisor after adjustment conference, reversing such denial is implemented (or the date Medicaid eligibility is approved, if earlier).

(2) Procedure and Notification

- (a)** Notices of Medicaid ineligibility provide applicants and recipients with information about their rights to appeal the agency's decision. These notices also contain specific information about the availability of direct reimbursement if a written appeal is filed and the State's initial decision is overturned as incorrect. The rules governing appeals and hearings are located in DHS and EOHHS rule section #0110.
- (b)** The EOHHS Appeals Office must provide individuals who may qualify with an Application for Reimbursement form to request repayment for medical expenses which they incurred and paid while their appeal was pending.
- (c)** The individual must complete and sign the Application for Reimbursement form and include: a) a copy of the provider's bill showing date and type of service; and b) proof that

payment was made by the recipient or a person legally responsible for the recipient between the date of the erroneous denial and the date of the successful appeal decision. The completed form and required documentation is returned to the appropriate department representative.

- (d) If either the bill or proof of payment is not included with the Application form, the Medicaid agency representative offers to assist the recipient in obtaining the required documentation, and sends a reminder notice requesting return of the required information within thirty (30) days from the date of receipt of the ~~MA-1R~~ Application for Reimbursement form. If all documents are not received within thirty (30) days, or if the documentation provided indicates that medical service or payment was not made between the date of Medicaid denial (or termination) and the date of Medicaid acceptance (or reinstatement), the agency representative denies the request for reimbursement.
- (e) Otherwise, the agency representative forwards a referral form (~~DHS-48R~~), attaching the recipient's written request for reimbursement and all supporting documentation to the Medicaid agency for a decision on payment. The Medicaid agency is responsible for providing the individual with written notification (~~DHS-40A or DHS-167A~~) of the agency's decision and rights to appeal.

0300.45.21 01. G. Severability
October 2013

If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.