

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

REV: June 2014

0300.01 A. 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 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 and, as such, is legally responsible for the fiscal management and administration of the Medicaid 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.

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

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

B. Purposes and Scope of the Medicaid Program

REV: June 2014

The Rhode Island Medicaid 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.

(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"> • Doctor’s office visits • Immunizations • Prescription and over-the-counter medications • Lab tests • Residential treatment • Behavioral health services 	<ul style="list-style-type: none"> • Home health care • Skilled nursing care • Nutrition services • Interpreter services • Childbirth education programs • Prenatal and post-partum care
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<ul style="list-style-type: none"> • Drug or alcohol treatment • Early and Periodic, Screening, Detection and Treatment (EPSDT)* • Referral to specialists • Hospital care • Emergency care • Urgent Care • Long-term Services and Supports (LTSS) in home and community-based and health care institution settings such as nursing homes 	<ul style="list-style-type: none"> • Parenting classes • Smoking cessation programs • Transportation services • Dental care • Expedited LTSS • Organ transplants • Durable Medical Equipment
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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.

0300.01 C. Program Administration

REV: 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 RItE Care managed care plan in accordance with Section 1310 or, as applicable, an employer health plan approved by the executive office for the RItE 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 RItE 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 RItE 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.

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:

- (i) Medicare Part D Wrap. Medicaid beneficiaries who receive Medicare Part A and/or Part B, qualify for Part D and must receive their pharmacy services through a Medicare-approved prescription drug plan. Therefore, these dually eligible Medicaid-Medicare beneficiaries are not eligible for the Medicaid pharmacy benefits. There are, however, certain classes of drugs that are not covered by Medicare Part D plans. Medicaid coverage is available to those receiving Medicare for these classes of drugs. The classes of drugs covered by Medicaid are: vitamins and minerals (with the exception of prenatal vitamins and fluoride treatment), Medicaid-approved over-the-counter medications, cough and cold medications, smoking cessation medications, and covered weight loss medications (with prior authorization). When purchasing these 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.
- (ii) Medicare Part D Cost-sharing Exemption. There is no Medicare Part D cost-sharing for full benefit Medicaid-Medicare dual eligible beneficiaries who would 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 Title XIX waiver authority, the Medicaid State Plan, or through enrollment in a Medicaid managed care organization. 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: Preventive/Core Services, Personal Choice, Habilitation, Shared Living, and Assisted

Living as well as the co-pay program administered by the Division of Elderly Affairs (DEA).

(2) Federal law and regulations authorize the Medicaid agency or its authorized contractual agent (managed care plan/organization) to place appropriate restrictions on a Medicaid-funded benefit or service based on such criteria as medical necessity or on utilization control (42 CFR§ 440.230(d)). The Medicaid *Pharmacy Lock-In Program* was established under this authority to restrict access to full pharmacy services in instances in which there is documented excessive use by a beneficiary. 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 beneficiaries from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

(a) *Enrollment.* Whenever Medicaid records indicate that beneficiary utilization is excessive or inappropriate given actual medical need, the Medicaid agency or its authorized contractual agent, may require an individual to designate a physician and pharmacy of choice for exclusive service 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 medical and pharmacological references.

(b) *Notice.* Beneficiaries determined to have excessive utilization are provided with written notice at least thirty (30) days prior to the imposition of the pharmacy lock-in restriction. Upon notification, beneficiaries are asked to choose a primary pharmacy/physician as a single source for all Medicaid health care. The notification will also advise the beneficiary that failure to cooperate will result in the Medicaid agency designating a physician/pharmacy to serve in this capacity based on other factors such utilization patterns and location. The notification includes a statement of the right to request a fair hearing within thirty (30) days if the beneficiary disagrees with the findings and the Medicaid agency's action.

(3) Primary Pharmacy of Choice

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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.

(4) Primary Care Physician

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- (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.
- (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.

(5) Change in Recipient Status

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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.

0300.01.E Cooperation Requirements

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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.

F. Direct Reimbursement to Beneficiaries

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- (1) Some individuals, while appealing a determination of Medicaid ineligibility, incur and pay for covered services. Direct reimbursement may be available to 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 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 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;
- 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 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, 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 of the agency's decision and rights to appeal.

0300.01.G. Severability

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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.