



## 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 a series of proposed new sections (as well as amendments to existing sections) of the Medicaid Code of Administrative Rules (MCAR) (“Regulations”) related to the expansion of the Medicaid Program under the provisions of health care reform statutes. (A summary of the rule changes appears below).

Under the authority granted in the federal Patient Protection and Affordable Care Act of 2010 (ACA) and applicable State law, including Executive Order 11-09, Rhode Island created its own health insurance marketplace and on-line eligibility system, previously referred to as a “health benefit exchange”, and elected to expand Medicaid eligibility to the new ACA coverage group of adults, without dependent children, who have income up to 133% of the Federal Poverty Level (FPL). On October 1, 2013 Rhode Islanders interested in obtaining health coverage under this new expansion group began applying through the health insurance marketplace (HealthSourceRI), the Department of Human Services (DHS) field offices or website, and/or the Executive Office of Health and Human Services website (EOHHS). Applicants deemed to be eligible began enrolling in one of two Medicaid health plans during the period from October 1, 2013 to December 31, 2013. Actual coverage begins on January 1, 2014.

There will be no changes in Medicaid coverage until January 1, 2014. The proposed rules seek to accomplish the following:

01. To describe the new income standard that will be used to determine access to coverage for the ACA expansion group beginning on January 1, 2014;
02. To amend existing Medicaid rules to provide for persons participating in Medicaid prior to January 1, 2014;
03. To identify the principal roles and responsibilities of the Medicaid agency and the State with respect to persons seeking eligibility for the new ACA expansion coverage group; and
04. To inform Rhode Islanders of their rights and responsibilities when seeking Medicaid eligibility as a member of the new ACA or existing coverage groups during this same period.

These regulations are being promulgated pursuant to the authority contained in Rhode Island General Laws Chapter 40-8 (Medical Assistance) as amended, including Public Law 13-144; Title XIX of the Social Security Act; 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); Rhode Island Executive Order 11-09; Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et. seq.*; Chapter 42-35 of the Rhode Island General Laws, as amended; and Chapter 42-7.2 of the Rhode Island General Laws, as amended.

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 were identified based upon available information.

Notice is hereby given in accordance with the provisions of Chapter 42-35 of the Rhode Island General Laws, as amended, that the Secretary will hold two Public Hearings on the above mentioned matter on **TUESDAY, 3 DECEMBER 2013** at which time and place all persons interested therein will be heard.

Hearings will be convened as follows:

Tuesday, December 3, 2013 <b>2:00 p.m.</b>	Tuesday, December 3, 2013 <b>6:00 p.m.</b>
<b>Arnold Conference Center</b> 111 Howard Avenue Regan Building Pastore Complex Cranston RI 02920	<b>DaVinci Center</b> 470 Charles Street Providence, RI 02904

For the sake of accuracy, it is requested that statements to be made relative to any aspect of the Regulations, including alternative approaches or overlap, be submitted in writing at the time of the hearing or mailed prior to the hearing date to: Steven M. Costantino, Secretary, Rhode Island Executive Office of Health & Human Services, Louis Pasteur Building, 57 Howard Avenue, Cranston, Rhode Island, 02920 or via email to the attention of: [eshelov@ohhs.ri.gov](mailto:eshelov@ohhs.ri.gov).

Interested persons may inspect said Regulations and other related materials on the Rhode Island Secretary of State's website: [www.sec.state.ri.us/rules](http://www.sec.state.ri.us/rules), on the Executive Office of Health & Human Services' website: [www.eohhs.ri.gov](http://www.eohhs.ri.gov) or at the Executive Office of Health & Human Services, 57 Howard Avenue, Cranston, Rhode Island, 02920 between the hours of 9:00 a.m. and 3:00 p.m., Monday through Friday; by calling (401) 462-1575 {via RI Relay 711} or by emailing [Eshelov@ohhs.ri.gov](mailto:eshelov@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.*

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Steven M. Costantino, Secretary  
Signed this 25<sup>th</sup> day of October 2013

### **Significant ACA-Related Changes in the Medicaid Program**

The following provides a summary of the major changes in the Medicaid program authorized or mandated by the ACA and the applicable rules in this chapter:

- Consolidation and simplification of Medicaid coverage groups subject to MAGI-based eligibility determinations – MCAR section 1301.
- Elimination of Medicaid eligibility for parents/caretakers with income from 133% to 175% of the FPL – MCAR 1301.
- Expansion of Medicaid eligibility to adults, ages 19 to 64, without dependent children and establishment of a new Medicaid affordable care coverage group – MCAR section 1301.
- Streamlined application process through the automated affordable care eligibility system – MCAR 1303.
- Standardization of Medicaid eligibility requirements for MACC coverage groups – MCAR Section 1305.

- Establishment of passive renewal process for making determinations of continuing eligibility – MCAR section 1306.
- Implementation of the MAGI-based income standard – MCAR section 1307.
- Automated verification of eligibility requirements through federal and State data sources – MCAR section 1308.
- Elimination of premiums in the RItE Care managed care delivery system and redefinition of RItE Care coverage groups – MCAR section 1309.
- Enrollment of the MACC coverage group for adults without dependent children in a Rhody Health Partners managed care plans with a modified benefit package – MCAR section 1310.
- Modifications of the managed care enrollment system to complement changes in the application and eligibility determination processes – MCAR section 1311.
- Changes in the RItE Share premium assistance program to complement ACA initiatives, remove premiums, and add a buy-in requirement – MCAR section 1312.
- Extension of the Communities of Care requirement to MACC expansion group – MCAR section 1314.
- Implementation of a limited subsidy program for parents/caretakers with income from 133% to 175% of the FPL who are no longer eligible for Medicaid affordable care coverage – MCAR section 1315.

## 0302 The Application Process

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.

### 0302.05 ~~The Request for MEDICAL ASSISTANCE~~ Medicaid

~~REV:01/2002 Repealed October 2013~~

~~The application process begins when an individual or his/her representative contacts the agency to request Medical Assistance and ends with:~~

- ~~• a decision by the Department of Human Services to approve or to deny assistance; or,~~
- ~~• a decision by the applicant to withdraw his/her request for assistance.~~

~~The purpose of the application process is to ensure that the application is fully considered and acted upon in a timely manner. It provides the individual an opportunity to state his/her needs and to learn what the agency can do in response.~~

~~It also provides the agency an opportunity to explain the individual's responsibilities in relation to the agency and the need to inform the agency of changes in circumstances which may affect eligibility for Medical Assistance.~~

~~A request for assistance may be received in a DHS office in person, by phone or by mail. When a request is received, a DHS staff member gives or mails the individual an application packet.~~

~~A request for Medical Assistance on behalf of a pregnant woman or family with a child under the age of nineteen (19) years may be received in locations other than district offices through outreach workers known as Family Resource Counselors (FRC's).~~

~~Currently FRC's are located in twelve participating community health centers and three hospital clinics statewide. The Family Resource Counselors screen pregnant women and young children for potential eligibility for Medical Assistance (and the Rite Care, WIC, and Food Stamp programs) and assist those thought to be eligible in the application process. The goal is to help non-cash assistance eligibles to obtain early pre-natal and pediatric health services.~~

## SECTION 0302 The Application Process

0302.05.05 The Request for A Medicare Part D Application

EFF:01/2006 Repealed October 2013

~~An individual who does not qualify for Medicaid or his/her representative has the option to contact either a Social Security Administration Office or a Department of Human Services Office to request~~

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~~an application for the Medicare Part D Program. This request may be received at a DHS office in person, by phone or by mail. When a request is received at a DHS Office, a DHS staff member gives or mails the individual an application for the Medicare Part D Program. At this time the DHS staff member should also provide the individual with an MPP-1 Application Form so that the individual may be reviewed for QMB or SLMB eligibility.~~

~~Completed applications may be submitted to either a Social Security Administration Office or a Department of Human Services Office. If a Medicare beneficiary insists that DHS process the application, the DHS representative is required to do so. If the beneficiary insists that the DHS representative process the application, the DHS representative must complete the process within sixty (60) days from the date the application is received.~~

**0302.10 Contents of the Application Packet**

REV:~~12/2004~~ October 2013

For persons seeking Medicaid eligibility under sections 0351, 0374, 0375, and 0378, The the application packet consists of the following documents:

<i>Individuals/Couples/QMB'S/QDWI'S</i>	<i>Families</i>
DHS-1 Application Form/	DHS 1 Application Form/
DHS-2 Statement of Need	DHS 2 Statement of Need or MARC 1 Application Packet
MA Booklet	DHS 14 Office Locations
DHS-14 Office Locations	R 11 EPSDT Information
QMB-2 Information for QMB's	
Transportation Information	
Return Addressed Stamped Envelope	Return Addressed Stamped Envelope

This packet provides information about the agency, the conditions under which ~~Medical Assistance~~ Medicaid is provided and an applicant's rights and responsibilities under the law. The family packet also provides an informational brochure on the ~~Department of Health's~~ state's WIC Program (women, infants and children's supplemental food program in Rhode Island) and the locations of participating WIC facilities.

The DHS-1 and the DHS-2 are the application documents for individuals, (including a blind or disabled child), couples and families which serve as the basis of the ~~MA~~ Medicaid eligibility determination. These forms and other supplementary forms, as appropriate, constitute an application for ~~Medical Assistance.~~ Medicaid.

**0302.10.05 Assistance in Completing the Application**

REV:~~06/1994~~ October 2013

An applicant is informed that a friend, relative, attorney, guardian or legal representative may assist in completing the application forms and that, if needed, an ~~Eligibility Technician~~ is also available for assistance.

Occasionally a completed application form is received in the district or regional office through the mail without any prior request for assistance. This occurs when credit departments of hospitals

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provide patients with the forms, and when ~~Central Office~~ the Medicaid agency mails an application form to an individual being terminated on SSI.

In such instances, there must be the usual response to the application for ~~Medical Assistance~~ Medicaid:

- The date of receipt must be noted on the application form;
- The applicant must be contacted, where appropriate, for information relative to eligibility;
- The application must be acted upon within the applicable time frame; and
- A notice of action must be provided to the applicant.

**0302.10.10 Who Must Sign the Application**

~~REV:11/2000~~ Repealed October 2013

~~The following individuals must sign the application:~~

- ~~• When two spouses are living together, both spouses must sign the application form;~~
- ~~• When two parents of a dependent child are living together, both parents must sign the application form.~~

~~The following individuals may sign the application form:~~

- ~~• A relative or non relative caretaker may file an application form for a child under the age of (19);~~
- ~~• An individual under the age of nineteen (19) who is living independently (and not merely "temporarily absent" from home as defined in Section 0328.10.10) may file an application;~~
- ~~• A relative may file an application on behalf of a deceased individual for retroactive coverage.~~

**0302.15 Decision on Eligibility**

~~REV:08/1999~~ October 2013

A decision on a ~~Medical Assistance~~ Medicaid application for individuals and families eligible under section 1301 and for aged and blind individuals is made within THIRTY (30) DAYS of the receipt of the application by the department. An eligibility decision for disabled individuals is made within NINETY (90) DAYS of the receipt of the application by the department.

An eligibility decision must be made within the above standards except in unusual circumstances when good cause for delay exists.

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Good cause exists: 1) when the agency representative cannot reach a decision because the applicant or examining physician delays or fails to take a required action, provided that the agency promptly reviews submitted medical and social data and requests any necessary additional medical documentation from the treating provider within two weeks from the date the completed forms MA-63 (Physician's Report), AP-70 (Information for Determination of Disability) and DHS-25M (Release) are received by the agency, or within two weeks of learning of the existence of a treating provider or of the need to obtain supplementary treating provider information; or 2) when there is an administrative or other emergency beyond the agency's control. The reason for the delay must be documented in the case record. In addition, the applicant must be provided with written notification stating: 1) the reason for delay; and 2) the opportunity for an expedited hearing to contest the delay.

The agency representative makes the decision on eligibility on the basis of information submitted on the application. In every instance, information regarding the applicant's income is verified. Other information is verified as required. Any information on the application which is questionable must be confirmed before eligibility can be certified.

For applications which require a determination of resources (i.e., all SSI related applications and some family-related applications), at least ONE (1) AP-91 FORM is sent to determine the amount of money in, or existence of, a bank account. The form is sent to the bank where the individual has or had an account. If no account is declared, the AP-91 is sent to the banking institution most likely to have been used by the individual considering the location of home and/or employment.

At redetermination, at least ONE (1) AP-91 form is sent, but to an institution, such as a bank or credit union, not selected at the time of the application.

If a decision cannot be made because of omissions or inconsistencies, the agency representative must contact the applicant by mail, phone or in person for clarification, additional information or verification. If it is necessary for the agency to obtain or confirm any information, the applicant is advised of the necessary steps s/he or the agency must take. If other collateral sources of information must be contacted, the applicant should be informed of why the information is necessary and how it will be used by the agency. The applicant must sign AP-25, Release of Information Authorization, and permit ~~DHS~~ the state to use public records and contact collateral sources for purposes of the eligibility determination.

If an applicant/recipient refuses to present information or verification required to reach a decision on an initial or continuing determination of eligibility and requests the agency not to obtain it, the agency would be unable to determine eligibility and would have no recourse but to deny or discontinue assistance.

In those instances where eligibility is based on the existence of the conditions of blindness or disability, additional medical information verifying these conditions is necessary. Appropriate forms and instructions are provided applicants for submitting this information.

### **0302.20 Period of Eligibility**

REV:05/1999 October 2013

When an individual is determined eligible for ~~Medical Assistance~~ Medicaid, eligibility exists for the entire first month. Therefore, eligibility BEGINS on the first day of the month in which the individual is determined eligible. ~~Medical Assistance~~ Medicaid ENDS when the individual is determined to no

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longer meet the program's eligibility requirements and proper notification has been given. ~~Medical Assistance~~ Medicaid benefits cease on the last day of the 10-day notice period when eligibility is determined to no longer exist.

However, in cases where the Flexible Test of Income policy is applied, eligibility is established on the day the excess income is absorbed; i.e., the day the medical service was provided.

Eligibility is for the balance of the six (6) month period.

The certification periods for ~~MA~~ Medicaid beneficiaries are as follows:

- Family, individual, and couple cases, with the exception of flexible test of income cases, are certified for ~~MA~~ Medicaid up to a maximum of TWELVE (12) MONTHS. Certifications may be for LESSER periods if a significant change occurs or is expected to occur that may affect eligibility. No re-certifications for families and children will be conducted during the period from January 1, 2014 to January 1, 2015.
- Flexible Test of Income cases are certified for ~~MA~~ Medicaid for the full SIX (6) MONTH (if eligible) or the BALANCE of the SIX (6) month period.
- Individuals eligible for benefits as a Qualified Medicare Beneficiary (QMB), a Special Low Income Medicare Beneficiary(SLMB) or a Qualified Working Disabled Individual (QWDI) are certified for a 12-month period. A Qualifying Individual (QI-1 or QI-2) is certified to the end of the calendar year.

Time limits for certification are established on the InRhodes Statement of Need Panel.

**0302.25 Certification of Eligibility**

REV:01/2002 October 2013

Written notice is sent to each applicant who files an application regarding his/her eligibility or ineligibility. When the applicant is found eligible, a NOTICE OF ELIGIBILITY is sent ~~via InRhodes~~ by the agency representative to notify the applicant of eligibility and the length of ~~MA~~ Medicaid certification.

~~Eligible homeless individuals and families who are unable to provide a mailing address are advised to pick up computer generated eligibility notices and MA cards at the District Office the next business day. Homeless individuals and families who cannot provide mailing addresses are further advised of the need to come to the District Office one month prior to the certification end date to re-apply for MA. If a homeless recipient without a mailing address does not contact the District Office by the end of the certification period, staff must close the case on the end date of the certification period. Homeless individuals and families are certified for a maximum of three months.~~

**0302.30 Payment Process**

REV:03/2002 October 2013

Payment for medical care provided within the MA Medicaid scope of services is made by the department's fiscal agent based on claims submitted by the provider of the medical service and supplies.

The fiscal agent utilizes the Medicaid Management Information System (MMIS) to review the claim and make payment.

~~Payment for services can also be made for unpaid medical services received in the three months prior to the month of application, provided the individual was eligible in that period. All bills are cleared for eligibility through the Division of Health Care Quality Financing and Purchasing, Center for Adult Health.~~

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 Plans 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.~~

**0302.30.05 MA Medicaid as Payor of Last Resort**

REV:06/1994 October 2013

Medical insurance is not a bar to eligibility. However, all benefits for which the recipient is eligible must be paid before the ~~Medical Assistance~~ Medicaid Program assumes responsibility for payment.

State law makes it illegal for insurance companies to exclude MA Medicaid recipients from benefits, reinforcing the requirement of third-party liability (TPL) and that MA Medicaid is the last payer.

~~The most common medical resources are Blue Cross/Blue Shield, Major Medical, Plan 100, Delta Dental, Harvard Community Health Plan of New England and Ocean State. Most employed people in Rhode Island are covered by one or a combination of these resources. Even in cases of separation, the family frequently continues to be covered by the absent parent's family coverage. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) now pays claims for dependents of service personnel who are also MA recipients.~~

~~Older applicants, or those who are blind or disabled, are usually eligible for Federal Medicare. This is frequently supplemented by "Blue Cross 65" and/or a commercial accident and health insurance policy.~~

~~If, in the clearance of a claim, the Division of Medical Services discovers the possibility of a resource, a notice is sent to the Eligibility Technician requesting this be followed up with the recipient. A follow up report regarding the results of the contact is submitted to the Division of Medical Services, at Central Office.~~

~~IT IS MOST IMPORTANT THAT THE POSSIBILITY OF EVERY MEDICAL RESOURCE BE EXPLORED AND THAT ANY RESOURCE AVAILABLE BE NOTED ON THE INRHODES~~

~~STATEMENT OF NEEDS FUNCTION. THE APPLICANT IS INSTRUCTED TO REPORT ANY NEWLY ACQUIRED RESOURCE.~~

### **0302.30.10 Direct Reimbursement to Recipients**

REV:03/2002 October 2013

Some individuals, while appealing a determination of ~~Medical Assistance (MA)~~ Medicaid ineligibility, incur and pay for covered services. To correct the inequitable situation which results from an erroneous determination made by the ~~Department~~ Medicaid agency, direct reimbursement is available to recipients 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 ~~MA~~ Medicaid coverage is received by the ~~Department~~ State within the time frame specified in Section 0110.20.
2. The original decision to deny or discontinue ~~MA~~ 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. 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 ~~MA~~ 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 ~~MA~~ Medicaid termination, if later) and before the date of the written decision issued by the ~~DHS EOHHS~~ Appeal Office, or decision by the Regional Manager/Chief Casework Supervisor after adjustment conference, reversing such denial is implemented (or the date ~~MA~~ Medicaid eligibility is approved, if earlier).

~~Example 1: An MA application is filed 9/1. A written notice of denial is issued on 10/1. On 10/15, a written request for appeal is received by the Department. The Appeal Office's decision, dated 12/1,~~

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~~finds that the original decision was incorrect and the individual is eligible for MA beginning in September. The agency representative approves MA eligibility on 12/2. To be considered for reimbursement, a medical expense must have been incurred and paid on or after 10/1 (date of denial) and before 12/2 (date appeal decision was implemented.)~~

~~Example 2: Application is filed 9/1. A notice is issued on 9/15 denying MA for September due to excess income and approving MA beginning 10/1. The individual sends in a written request for an adjustment conference on 10/10. Upon review, the Chief Casework Supervisor finds that the original decision to deny MA was incorrect; the individual is eligible beginning September 1. MA eligibility is approved on 10/20.~~

~~To be considered for reimbursement, a medical expense must have been incurred and paid on or after 9/15 and on or before 9/30.~~

~~Example 3: A redetermination of continuing eligibility is completed and a notice of MA discontinuance is issued on 9/15. MA is discontinued effective 9/30. A written request for appeal is received on 10/12. In her written decision on 12/2, the Appeals Officer finds that the Department's original decision to discontinue MA was incorrect; MA must be reinstated beginning 10/1. MA is approved on 12/11. To be considered for reimbursement, a medical expense must have been incurred and paid on or after 10/1 and before 12/11.~~

- ~~5. At the time the service was provided, the individual was eligible for MA and the service was within the covered scope of services, categorically needy or medically needy, allowed for the recipient.~~
- ~~6. A MA vendor payment would otherwise have been made at the time the service was provided, except that the provider does not have to be participating in the MA program.~~
- ~~6. The service was medically necessary when provided. However, prior approval requirements do not apply to such services.~~
- ~~7. Third party reimbursement is not available for the service.~~
- ~~8. Direct reimbursement may only be provided within the MA fee schedule in effect at the time the service in question was provided, even if the individual paid more than that amount.~~

### Procedure and Notification

~~The Department's notices Notices of MA Medicaid ineligibility provide applicants and recipients with information about their rights to appeal the agency's decision. These notices also contains specific information about the availability of direct reimbursement if a written appeal is filed and the Department's State's initial decision is overturned as incorrect. The rules governing appeals and hearings are located in DHS and EOHHS rule section #0110.~~

~~The written request for appeal is completed by the applicant or recipient and returned to the local DHS office. The agency representative, responsible for the case, completes the Department response. If upon receiving the request for hearing, the original decision is reversed and MA is reinstated, that information and the reason for reinstatement is noted in the Department response section of the~~

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~~hearing request form. The completed form is forwarded to the Appeals Office in accordance with policy in Section 0110.~~

~~If the original decision is reversed and MA is reinstated at any other time prior to the hearing, the Department representative sends written notification of the date of and reason for reinstatement to the Appeals Office.~~

The EOHHS Appeals Office ~~provides~~ 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. ~~The form contains instruction for completion and return to the local DHS office.~~

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.

If either the bill or proof of payment is not included with the Application form, the ~~Department Medicaid agency~~ representative offers to assist the recipient in obtaining the required documentation, and sends ~~an InRhodes SPEC~~ a reminder notice requesting return of the required information within thirty (30) days from the date of receipt of the MA-1R. 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 MA Medicaid denial (or termination) and the date of MA Medicaid acceptance (or reinstatement), the agency representative denies the request for reimbursement. ~~A DHS 167A is completed and mailed, along with DHS form 121, to the recipient.~~

Otherwise, the agency representative forwards a referral form (DHS-48R), attaching the recipient's written request for reimbursement and all supporting documentation to the ~~DHS Administrator in the Center for Adult Health, or his/her designee,~~ Medicaid agency for a decision on payment. The ~~Center for Adult Health-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.

### **For Further Information or to Obtain Assistance**

October 2013

01. Applications for affordable coverage are available online on the following websites:
  - [www.eohhs.ri.gov](http://www.eohhs.ri.gov)
  - [www.dhs.ri.gov](http://www.dhs.ri.gov)
  - [www.HealthSourceRI.com](http://www.HealthSourceRI.com)
02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-447-7747.
03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1-855-840-HSRI (4774).

**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.