



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

~~0302 The Application Process~~ Medicaid Application – Integrated Health Care Coverage Groups
~~October 2013~~ REV: June 2014

~~A. 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.~~ The Executive Office of Health and Human Services (EOHHS) has taken the opportunity pursuant to the federal Affordable Care Act (ACA) of 2010 to reorganize Medicaid/CHIP coverage groups based on the financial standard used to determine eligibility as well characteristics. All populations subject to the modified adjusted gross income (MAGI) standard have been reorganized into the Medicaid Affordable Care Coverage groups. (See the Medicaid Code of Administrative Rules (MCAR) sections 1301 and 1303). Populations exempt from the MAGI who must also meet both clinical and financial eligibility criteria have been reclassified into the Integrated Health Care Coverage (IHCC) groups. This rule applies only to persons applying for Medicaid who are in the following IHCC groups:

- Low-income 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.
- Persons of any age who require long-term services and supports in an institutional or home and community-based setting, including children seeking eligibility under the Katie Beckett provision.
- Low-income elders and persons with disabilities who applying for the Medicare Premium Payment Program (MPPP) in which Medicaid pays the Medicare Part A and/or Part B premiums for qualified beneficiaries.
- Medically needy individuals seeking to obtain Medicaid eligibility by applying a flexible test of income that enables the individual to “spend down” to the medically needy income limit (MNIL).

~~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 Medicaid**~~

~~Repealed October 2013~~

~~**Section 0302 The Application Process**~~

~~0302.05.05 The Request for A Medicare Part D Application~~

~~Repealed October 2013~~

0302.10 B. Contents of the Application Packet

~~REV: October 2013~~ June 2014

For persons seeking Medicaid eligibility in the applicable IHCC groups under MCAR sections 0351, 0374, 0375, and 0378, the application packet consists of the following documents:

<i>Individuals/Couples/QMB'S/QDWT'S IHCC Groups</i>
DHS-1 Application Form/
DHS-2 Statement of Need Application for Assistance
MA <u>Medicaid</u> Booklet
DHS-14 Office Locations
QMB-2 Information for QMB's
Transportation Information
Return Addressed Stamped Envelope

This packet provides information about the agency, the conditions under which Medicaid is provided, and an applicant's rights and responsibilities under the law. ~~The family packet also provides an informational brochure on the 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~~ Any applicants for Medicaid health coverage in the IHCC groups must complete and submit in-person or by mail the required application documents and any additional supplemental forms that may be necessary in order for an eligibility decision to be made within the timelines set by the agency. ~~for individuals, (including a blind or disabled child), couples and families which serve as the basis of the Medicaid eligibility determination. These forms and other supplementary forms, as appropriate, constitute an application for Medicaid.~~ Beginning in January 2015, applicants for Medicaid health coverage in the IHCC groups will also have the option of completing and submitting the application either:

- 1) on-line through the State's new web-based eligibility system;
- 2) in-person; or
- 3) by mail.

0302.10.05 C. Assistance in Completing the Application

REV: ~~October 2013~~ June 2014

An applicant is informed that Any person applying for Medicaid health coverage may obtain the assistance of a friend, relative, attorney, guardian or legal representative, or an agency representative or other application expert working for or on behalf of the EOHHS ~~may assist in when~~ completing the required application forms, and that, if needed, a 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 provide patients with the forms, and when 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 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 D. Who Must Sign the Application Signature or Attestation

REV: June 2014

All applicants for Medicaid health coverage must attest to the truthfulness of the application information they provide by hand-signing or electronically attesting to a sworn statement to that effect. Whether other members of the applicant's household or family may or must also sign the application varies as follows:

- When two spouses are living together, both spouses must sign the application form;
- A caretaker may sign and file an application form for a child with disabilities or special needs who is under the age of (19);
- A relative may file an application on behalf of a deceased individual for retroactive coverage.

0302.15 **E. Timeliness Standards for** Decisions on Eligibility

REV: ~~October 2013~~ June 2014

A decision on a Medicaid application for individuals and families eligible under section 1301 of the MCAR and for ~~aged and blind individuals~~ persons who are blind or low-income elders in the IHCC groups is made within THIRTY (30) DAYS of the receipt of the completed application by the ~~department~~ EOHHS, or the Department of Human Services (DHS) while operating under an agreement with the EOHHS to make eligibility determinations on its behalf. An eligibility decision for ~~disabled individuals~~ a person who has a disability and/or is seeking Medicaid-funded long-term services and supports must be is made within NINETY (90) DAYS of the receipt of the completed application by the ~~department~~ EOHHS or DHS.

(1) Good cause exemption for determination delay – IHCC groups only. An eligibility decision ~~must be made within the above~~ may exceed the timeliness standards ~~except~~ in unusual circumstances when good cause for a delay exists. Good cause exists when:

(a) ~~when the~~ The agency representative cannot reach a decision because the applicant or ~~examining the applicant's treating~~ physician or other provider responsible for providing information material to the application 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 (e.g., Physician's Report), AP-70 (Information for Determination of Disability) and DHS-25M (Release of Information Authorization)~~ 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

(b) ~~when there~~ 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.

(2) Basis for making a determination. 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.~~

(a) 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 ~~the~~ **the applicant** or the agency must take **before a determination of eligibility can be made**. 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, **a Release of Information Authorization**, and permit the ~~state~~ **State** to use public records and contact collateral sources for purposes of the eligibility determination.

(b) If an applicant/~~recipient~~ **or beneficiary** refuses to ~~present~~ **either provide the information the agency requests** or ~~verification required to reach a decision on an initial or continuing determination of eligibility~~ **sign the release(s) necessary for the agency to obtain the information on its own** and requests the agency not to obtain it, the agency ~~would be unable to determine eligibility and would have no recourse but to~~ **will deny or discontinue assistance Medicaid health care coverage**. 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 D. Period of Eligibility

REV: ~~October 2013~~ **June 2014**

Written notice is provided to each applicant stating the Medicaid agency's eligibility decision, the basis for the decision, and an applicant's right to appeal and request a hearing. In instances in which the applicant is determined to be eligible, a notice is provided indicating the length of time the applicant will remain eligible – the "eligibility period" -- until before a renewal of continuing eligibility is required. The period of Medicaid eligibility for IHCC group members is as follow:

(1) **General eligibility period.** When **an** individual is determined eligible for 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. Medicaid ends when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given **or the beneficiary fails to renew eligibility as required**. Medicaid benefits cease on the last day of the ~~10-day~~ **ten (10) day** notice period when eligibility is determined to no longer exist. **Individual and couple cases remain eligible for Medicaid for 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.**

(2) **Special eligibility period – Medically-needy.** ~~However, in~~ **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~~ **health** service was provided). **Eligibility is for the balance of the six (6) month period. Medically-needy eligibility continues for the full six (6) months or the balance of the six (6) month period.**

The certification periods for Medicaid beneficiaries are as follows:

- ~~Family, individual, and couple cases, with the exception of flexible test of income cases, are certified for 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 Medicaid for the full SIX (6) MONTH (if eligible) or the BALANCE of the SIX (6) mont

(3) Medicare Premium Payment Program. 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: 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 by the agency representative to notify the applicant of eligibility and the length of Medicaid certification.~~

0302.30 Payment Process

REV: October 2013

~~Payment for medical care provided within the 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.~~

~~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.~~

0302.30.05 E. Medicaid as Payor of Last Resort

REV: October 2013 June 2014

Medical Health insurance coverage from another party is not a bar to Medicaid eligibility. However, as the payor of last resort, Medicaid payment is only made for services that are not covered by a beneficiary's other forms of health insurance. In addition, beneficiaries are required to sign over to the Medicaid agency their right to any such third party payments at the time application is made. ~~all~~ benefits for which the recipient is eligible must be paid before the Medicaid Program assumes responsibility for payment. State law makes it illegal for insurance companies to exclude Medicaid recipients beneficiaries from benefits, reinforcing the requirement of third-party liability (TPL) and that Medicaid is the last payer. (See sections 40-8-4 and 40-6-29 of the Rhode Island General Laws, as amended).

0302.30.10 Direct Reimbursement to Recipients

REV: October 2013

~~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 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 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. 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).~~

Procedure and Notification

~~Notices of 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 State's initial decision is overturned as incorrect. The rules governing appeals and hearings are located in DHS and EOHHS rule section #0110.~~

~~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.~~

~~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 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. 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.~~

~~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.~~

For Further Information or to Obtain Assistance

March 2014

1. Applications for affordable coverage are available online on the following websites:
 - www.eohhs.ri.gov
 - www.dhs.ri.gov
 - www.HealthSourceRI.com
2. 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 1-855-609-3304 and TTY 1-888-657-3173.
3. 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.