



## 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.

**0310 Retroactive Coverage**

**0310.01 Applicability**

October 2013

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.

**0310.05 Retroactive Coverage Defined**

~~REV:07/2002~~ October 2013

~~Categorically Needy and Medically Needy individuals~~ Medicaid beneficiaries who meet the SSI-related eligibility criteria may request retroactive eligibility for UP TO THREE (3) MONTHS PRIOR TO THE MONTH OF APPLICATION. To obtain retroactive coverage, applicants must meet all eligibility criteria during the retroactive period.

Retroactive coverage is also available to IV-E and non IV-E foster children and adoption subsidy family-related coverage groups.

~~Retroactive coverage for the three (3) months prior to the month of application is not available to members of all other family related coverage groups, including Section 1931 families, Waiver Families, Medically Needy Families (including flex test cases), Rite Care or Rite Share pregnant women and children, all Rite Care State funded coverage groups, and all Extended Family Planning coverage groups.~~

The following chart details the family-related coverage groups who are eligible/ineligible for retroactive services:

<i>Coverage Group</i>	<i>Eligible For Retro</i>
<del>Section 1931 MA (including FIP)</del>	<del>N</del>
<del>Family Waiver MA income greater than 110% FPL</del>	<del>N</del>
<del>Pregnant women income less than or equal to 250% FPL</del>	<del>N</del>
<del>Children up to age 19 income less than or equal to 250% FPL</del>	<del>N</del>
IV-E and non IV-E Foster Children	Y
Adoption Subsidy Children Coverage Groups	Y
<del>Medically Needy (includes Flex Test) family related groups</del>	<del>N</del>
SSI-related coverage groups categorically or medically needy	Y
Non-citizens who are ineligible for ongoing <del>medical assistance</del> <u>Medicaid</u> due to immigration status - All coverage groups	Y

At the time of application for ~~Medical Assistance-Medicaid~~, if the applicant indicates that an unpaid medical bill was incurred in the three month period preceding the application, eligibility for retroactive coverage must be determined.

**Draft Rule: For Public Comment**

Current eligibility for SSI, ~~FIP RI WORKS~~, or ~~Medical Assistance~~ Medicaid does NOT affect retroactive eligibility. Individuals who are denied SSI, ~~FIP RI WORKS~~, or ~~MA~~ Medicaid in the month of application may be eligible for retroactive coverage.

An applicant need not be alive when an application for retroactive coverage is filed.

Retroactive eligibility is not available to persons who were not residents of Rhode Island in the retroactive period and at the time the service was provided.

**0310.10 Eligibility Requirements**

REV:~~04/2004~~ October 2013

Retroactive coverage applies only to unpaid medical bills for services provided within the scope of the ~~Medical Assistance (MA)~~ Medicaid Program. The medical bills must have been incurred during the three month retroactive period. The applicant must meet ~~MA~~ Medicaid eligibility requirements for each month in which an unpaid medical bill was incurred. Thus, retroactive eligibility may be determined for one, two, or three months of the retroactive period.

ONLY THE INCOME AND RESOURCES AVAILABLE TO THE APPLICANT IN THE RETROACTIVE PERIOD ARE USED TO DETERMINE ELIGIBILITY.

All services are subject to the same Title XIX utilization review standards as all other medical services of the ~~Medical Assistance~~ Medicaid Program.

**0310.15 Procedures for Determining Retroactive Eligibility**

REV:~~07/2002~~ October 2013

In determining retroactive eligibility, the applicant's net income (after allowable deductions and disregards) and resources are compared to Medically Needy limits UNLESS the unpaid medical bill is for Categorically Needy service only. In this case, eligibility must be based on the applicable Categorically Needy limits.

To determine retroactive eligibility, complete the following:

- Verify that the bill is unpaid and is for a covered service provided within the three (3) months prior to the first of the month of application for SSI, ~~FIP RI WORKS~~, or ~~MA~~ Medicaid.
- Establish eligibility based on:
  - Residence
  - Characteristic (if required)
  - Relationship (if required)
  - Citizenship or alienage; and at the time of application, the applicant must fulfill cooperation and enumeration requirements.
- Compare the resources and net income (after allowable deductions and disregards) to the appropriate income limit for the month(s) in which there is a verified, unpaid bill(s) (income limits refer to Categorically Needy income limits, Medically Needy income limits and Low

## Draft Rule: For Public Comment

Income Aged and Disabled income limits). Resources must be within the applicable resource limit as of the first day of each month for which eligibility is being determined.

- Determine whether retroactive coverage is available to individual's coverage group.
- If eligible, certify the case for the month or months of eligibility. Retroactive eligibility is for one (1), two (2), or all of the three (3) months immediately preceding the month of application.
- If the income exceeds the Medically Needy Income Limits apply the Flexible Test of Income. If the Flexible Test of Income results in achieving MA Medicaid retroactive eligibility, only those bills not applied to excess income are authorized for retroactive coverage.

If the bill is for a service not provided under the Medically Needy scope of services, the application must be determined for eligibility as Categorically Needy.

- If an unpaid bill is for a Categorically Needy service and the applicant's income exceeds the Categorically Needy Income Limits, the application for retroactive eligibility is denied. There is no Flexible Test of Income for income in excess of the Categorically Needy Income Limits.
- If unpaid bills for both Medically Needy and Categorically Needy services are submitted, the applicant must be found eligible as Categorically Needy or the bill(s) for the Categorically Needy service(s) must be denied. If the individual is eligible as Medically Needy, only the bill(s) for Medically Needy services can be authorized for retroactive coverage.

### **0310.20 Authorization of Retroactive Eligibility**

REV:01/2004 October 2013

Retroactive eligibility is determined on a month by month basis, ~~with the eligibility technician or social caseworker using the InRHODES Eligibility (ELIG) function to review and approve results.~~

No bill can be paid unless it is submitted by the provider and received by the ~~Center for Adult Health Medicaid agency~~ WITHIN TWELVE (12) MONTHS OF THE DATE THE SERVICE AS PROVIDED.

A copy of each medical bill or other verification that a medical expense exists during the retroactive period must be included in the case record to support the decision on the application.

### **0310.21 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.