**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<br>**2:00 p.m.** | Tuesday, December 3, 2013<br>**6:00 p.m.** |
|---|---|
| **Arnold Conference Center**<br>111 Howard Avenue<br>Regan Building<br>Pastore Complex<br>Cranston RI 02920 | **DaVinci Center**<br>470 Charles Street<br>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.

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, on the Executive Office of Health & Human Services' website: 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.

*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 25th 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.

**0318 ~~*MEDICAL ASSISTANCE*~~ Medicaid Redetermination**

**0318.01 Applicability**
October 2013

The provisions in this section do not apply to the individuals and families in the Medicaid affordable coverage groups identified in MCAR section 1301 that take effect on January 1, 2014. The rule governing the renewal process for the Medicaid members in these groups are located in MCAR section 1306. Individuals and families who were determined eligible prior to January 1, 2014 and were still enrolled on that date are not subject to a determination of continuing eligibility until 2015 unless there is a change in an eligibility factor for example, income or family size. If such a change occurs, the provisions in MCAR section 1301 and 1306 apply. **Accordingly, the provisions of this section are applicable only to individuals and families who are not subject to the modified adjusted gross income standard (MAGI) on or after January 1, 2014. The characteristics of these "non-MAGI" coverage groups are identified in MCAR section 1301.**

**0318.05 Redetermination of ~~Ma~~ Medicaid Eligibility**
REV:~~05/1999~~ October 2013

The redetermination of ~~MA~~ Medicaid eligibility is based on ~~a new application (DHS-2 or MARC-1)~~ the review and update of eligibility factors subject to change and, as appropriate, supporting documents, as needed, from which a determination is made that the recipient continues to meet all eligibility requirements.

A redetermination results in a recertification ~~at~~ for the existing scope of services, recertification for a reduced scope of services or case closure. Redetermination precedes a case closure. A case is not closed without a positive finding of ineligibility.

For ~~Categorically Needy and~~ Medically Needy INDIVIDUALS and FAMILIES, a full redetermination is completed every twelve (12) months. In addition, eligibility must be re-determined whenever a change in circumstances occurs, or is expected to occur that may affect eligibility.

~~Although the newborn is deemed eligible at birth, the birth itself is a change in household composition that always requires redetermination of continuing eligibility for the mother, the newborn and the rest of the family, either for FIP or Medical Assistance only~~.

**0318.10 Redetermination Process**
REV:~~12/2001~~ October 2013

Two months prior to the end of a certification period, InRHODES identifies cases due for re-determination and sends to the Management Information Systems (MIS) Unit at the DHS EOHHS Central Office a list of the cases and a name and address label for each case.

The MIS Unit sends the cards, labels and list of cases due for redetermination to the appropriate district office from which redetermination packets are mailed. The list provided to the district office identifies cases as family or adult and also indicates whether the case was previously certified using the DHS-2 or MARC-1 application form.

The redetermination packet consists of the following materials, (plus other forms, and documents as they relate to the individual situation; e.g., the MA-1 Supplement when a spenddown is indicated).

| ***INDIVIDUALS/COUPLES*** | ~~***FAMILIES***~~ |
|---|---|
| DHS-2 Statement of Need | ~~DHS-2 Statement of Need OR, as appropriate, MARC-1 Mail-In Application~~ |
| Transportation Information | ~~EPSDT Information~~ |
| Pre-addressed return envelope | ~~Pre-addressed return envelope~~ |
| | |

When the application form is returned within the required time period (prior to expiration of the certification period), the eligibility worker compares the information on the new application to the InRHODES record, entering changes once necessary verification has been provided. If the information is the same and the client remains eligible, the recipient's next redetermination date is advanced up to twelve months, as appropriate. If new information results in ineligibility or a change in the level of coverage, the worker must approve the results.

If the application is not received by the 20th of the month or ten days prior to the end of the certification period, the worker enters a non-cooperation code on the InRHODES STAT/STAT panel causing a TEN-DAY NOTICE of discontinuance to be sent.

The case closes at the end of the old certification period if the recipient has not responded by the end of the 10-day notice period.

**0318.15 Redetermination in Short Term Flex Test Case**
REV:~~01/2002~~ October 2013

Medically Needy Individuals/Couples ~~and Families~~ who are eligible under the flexible test of income are certified for the full six (6) month period of flex test eligibility or the balance remaining on the six (6) month period once spenddown of excess income is achieved.

A flexible test case accepted for two months or less requires an expedited redetermination process. Since the time between the notice of acceptance and the notice of impending discontinuance is shortened, redetermination activity should begin at the time of approval. For cases accepted for less than two (2) months, the time between sending of the application and sending of the notice of eligibility will be shortened. For instance, when a case is accepted during the last two weeks of the flexible test period, the redetermination packet, and the Notification of Eligibility are sent at about the same time.

Many cases accepted using the flexible test of income will have a period of ineligibility between the expiration date of one period and the date of eligibility for a subsequent flex test period.

**0318.20 Redetermination of Disability Determination**
REV:~~09/2005~~ October 2013

When the MART determines after review that a recipient's disability continues, it must also determine whether medical improvement is expected; and if so, when this review should be

conducted. ~~This information must be recorded in the case file. The active case should contain the review date of the disability on the InRhodes STAT/DISA panel. The next disability review date is set in accordance with the review date established by the Mart unless one of the factors set out below requires an earlier redetermination of the disability.~~

Cases are reviewed in order to determine whether or not an individual's disability has improved medically to the point where he/she is able to work. When determining whether a medical condition has improved, ~~DHS~~ the Medicaid state agency uses a point of comparison to compare the current severity of the impairment(s) to the most recent favorable disability determination that the individual has received.

When the MART has decided that a case must be reviewed in the future, all medical documentation, must be sent to the MART for review at the specified time period.

The ~~Department of Human Services (DHS)~~ the Medicaid state agency conducts continuing disability reviews when one or more of the following apply in accordance with 20 CFR, Section 416.990(b) ~~apply~~:

- The date the MART has rescheduled for the expected medical improvement review;
- A recipient has been scheduled for a periodic review by the MART in accordance with Paragraph 1.
- Current medical or other reports are necessary to determine if a recipient's disability has continued (for example, where medical technology has changed);
- A recipient returns to work and successfully completes a trial period of work;
- A recipient informs ~~DHS~~ the Medicaid agency that s/he has recovered from disability or that they have returned to work, or Vocational Rehabilitation reports recipient is working or is able to work;
- Someone in a position to know of recipient's physical or mental condition informs ~~DHS~~ the Medicaid agency that the recipient is not disabled, has not been following prescribed treatment, or has returned to work, and it appears that the report could be substantially correct; or
- ~~DHS~~ The Medicaid agency receives evidence that raises a question as to whether or not an individual's disability continues;
- A recipient has earned substantial wages during the eligibility period, unless otherwise eligible under the Sherlock Act, R.I.G.L. 40-8.7;
- By his/her first birthday, for a child whose low birth weight was a contributing factor material to the disability determination; or
- After his/her first birthday for a child who has an impairment(s) that is not expected to improve by his/her first birthday.

There are several definitions that are important to know in order to understand why an individual's disability determination would be reviewed.

**Definitions**

**Medical Improvement**: Any decrease in the medical severity of an individual's impairment(s) which was present at the time of the most recent favorable medical decision that they were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be made on improvement in the symptoms, signs and/or laboratory findings associated with the individual's impairment(s).

**Medical Severity:** Medical evidence that establishes a physical or mental impairment or combination of impairments of sufficient severity as to be the basis of a finding of inability to engage in any substantial gainful activity.

**Point of Comparison**: When determining whether medical improvement has occurred, compare the current medical severity of the impairment(s) to the medical severity of the impairment(s) which was present at the time the most recent favorable medical decision of disability was made.

~~**DHS,**~~ The Medicaid agency upon initiating a continuing disability determination review, will notify the individual by a written notice advising that:

- ~~DHS~~ The Medicaid agency will be reviewing the individual's disability;
- The reason why the disability is being reviewed;
- There are medical improvement standards as listed in 20 CFR, Section416.994(b)(1)(ii),(iii),(iv) and ~~DHS~~ Medicaid Code of Administrative Rules (MCAR) ~~Policy~~ Section 0318.20 that apply;
- The individual has a right to submit medical and/or other evidence to be considered in the review process;
- That the review could result in a later decision to discontinue the individual's ~~Medical Assistance~~ Medicaid benefits.

During the continuing disability determination review, ~~DHS~~ the Medicaid agency uses reasonable efforts to obtain the individual's medical reports and develop a complete medical history consisting of at minimum the preceding twelve (12) months.

The MART has the right to request and obtain a consultative examination from the recipient.

An individual's ~~Medical Assistance~~ Medicaid benefits will not be terminated for lack of disability until ~~DHS~~ the Medicaid agency has completed the review, determined that the individual has improved medically, or that under standards set out in 20 CFR Section 416.994(b)(3) or (4) has determined that an exception applies, and sent a timely and adequate written advance notice to the individual.

An individual's ~~Medical Assistance~~ Medicaid benefits will be discontinued if the individual refuses to:

1. Obtain a consultative examination, or
2. Cooperate in obtaining the required documentation.

**Evaluation**

To assure that disability reviews are conducted with uniformity, objectivity, and expeditiously, the following steps as referenced in 20 CFR Section 416.994(b)(5) will be followed when determining whether or not an individual's disability continues:

**Step 1:** An individual has an impairment or combination of impairments that meets or equals the severity of an impairment as listed in 20 CFR Section 416.994, Appendix 1, Subpart P of Part 404.

If the individual does, the disability will be found to continue.

**Step 2:** If an individual does not meet Step 1, has there been medical improvement in the individual's condition as shown by a decrease in medical severity (as defined). If not, there has been no medical Improvement and the individual's disability will be found to continue.

**Step 3:** If there has been medical improvement, determine whether it is related to the individual's ability to work, (i.e., whether there has been an increase in the residual functional capacity based on the impairment(s) present at the time of the most recent favorable disability determination).

**Step 4:** If there is no medical improvement or the Medical improvement is not related to the individual's ability to work, the individual's disability is found to continue.

**Step 5:** If there is medical improvement and it is shown to be related to an individual's ability to work, all of the individual's current impairments are reviewed to determine whether they are severe as defined in 20 CFR Section 416.921, and whether the impairments in combination significantly limit basic work activities.

**Step 6**: If an individual's impairment(s) is severe, s/he will be assessed to determine his/her ability to do substantial gainful activity in accordance with 20 CFR Section 416.961. The individual's residual functional capacity based on all of their current impairment(s) is assessed to determine whether s/he can still do the work that was done in the past. If s/he can do such work, the individual's disability will be found to have ended.

**Step 7:** If an individual cannot perform the work that s/he has done in the past, one final step must be considered. Given the individual's residual functioning capacity assessment and considering his/her age, education, and past work experience, are reviewed to determine if other work can be performed. If the individual can perform other work, the disability will be considered to have ended. If the individual cannot perform other work, the disability will be considered to have continued. All individuals are tested to evaluate the possibility of another eligibility category of ~~medical assistance~~ Medicaid before ~~Medical Assistance~~ Medicaid benefits are discontinued.

**0318.21 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.