

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services



Access to Medicaid Coverage Under the Affordable Care Act

Section 1300:

**Overview of Affordable Care Coverage
in Rhode Island**

December 2013

Rhode Island Executive Office of Health and Human Services
Access to Medicaid Coverage Under the Affordable Care Act
Rules and Regulations Section 1300:
Overview of Affordable Care Coverage in Rhode Island

TABLE OF CONTENTS

<i>Section Number</i>	<i>Section Name</i>	<i>Page Number</i>
	1300: Overview of Affordable Care Coverage in Rhode Island	
1300.01	Overview	1
1300.02	Scope and Purpose	1
1300.03	Applicability	3
1300.04	The Medicaid Single State Agency – RI Executive Office of Health and Human Services (EOHHS)	3
1300.05	The Medicaid Section 1115 Waiver	5
1300.06	EOHHS and ACA Implementation	5
1300.07	Significant ACA-Related Changes in the Medicaid Program	6
1300.08	One Application, No Wrong Door, Medicaid First	7
1300.09	Outreach and Enrollment Support Program: Assistors and Navigators	7
1300.10	HealthSourceRI	8
1300.11	For Further Information or to Obtain Assistance	8
1300.12	Severability	9

Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1300 of the Medicaid Code of Administrative Rules entitled, “Overview of Affordable Care Coverage in Rhode Island”** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), 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; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et. seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in the "Access to Medicaid Coverage Under the Affordable Care Act: New and Existing Eligibility Groups" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State on an emergency basis on September 20, 2013.

1300 Affordable Care Coverage in Rhode Island

1301.01 Overview

The goal of the federal Affordable Care Act (ACA) of 2010 is to improve access to high quality health coverage for people of all ages and income levels. In keeping with this purpose, the ACA made several significant changes in Medicaid requirements and offered the states the opportunity to expand eligibility to childless adults and to recast Medicaid as one of the forms of affordable care coverage that consumers can access through state-administered health insurance exchanges. Rhode Island is among the states that elected to take both options shortly after the enactment of the ACA.

The principal focus of ACA implementation in Rhode Island over the last two years has been building a unified, web-based information processing system with the capacity to determine eligibility for both publicly and privately-financed forms of affordable coverage, including Medicaid. To maximize access, the ACA required the adoption of a single standard for evaluating the income-eligibility of anyone applying for affordable coverage, irrespective of payer – that is, whether paid for in whole or in part by Medicaid, federal premium tax credits or cost-sharing subsidies, or by an employer or some other payer. This standard – modified adjusted gross income (MAGI) – uses information from federal tax filings to determine income and, in doing so, the range of affordable coverage choices available to an applicant. Accordingly, Rhode Island’s new unified health information system uses this standard and is, as such, designed to be the eligibility engine for accessing affordable coverage through the State’s health insurance benefit exchange, HealthSourceRI, as well as Medicaid.

On October 1, 2013, HealthSourceRI and the affordable care eligibility system that provides its functionality went live. Medicaid-eligible members of the ACA expansion group – adults 19 to 64 without dependent children – were able to access the system and use a single, stream-lined application to apply for Medicaid and all other forms of affordable coverage available through the ACA. On January 1, 2014, Medicaid eligibility for most other people under the age of sixty-five (65) also will be determined through this system. Over the course of the next two years, the functionality of the system will be gradually expanded to cover Medicaid eligibility determinations for individuals who are aged, blind or disabled or in need of long-term services and supports.

1300.02 Scope and Purpose

The January 1, 2014 start date for implementing the Medicaid provisions of the ACA, expanding coverage and transitioning to the new MAGI-based eligibility system have all required the State to make significant changes in the program requirements for the Medicaid-eligible individuals and families that will be affected. Taken together, these changes will result in a fundamental redesign of many aspects of the Medicaid program and render the rules that govern them obsolete. Rather than overhauling the applicable rules already on the books, the State has elected use to establish a new chapter in the Medicaid Code of Administrative Rules (MCAR) that sets forth in plain language the rules governing access to affordable coverage through the Medicaid program beginning on January 1, 2014. The purpose of this rule is to establish the role and responsibilities of the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, in implementing the provisions in the rules in each section of the new code, and to provide a general summary of the changes that will take effect on January 1, 2014.

1300.03 Applicability

Effective January 1, 2014, the rules in this chapter govern Medicaid eligibility for all NEW applicants subject to the MAGI standard in the following Medicaid Affordable Care Coverage (MACC) groups:

- (01) Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.
- (02) Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child’s citizenship and residence is the basis for eligibility.
- (03) Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.
- (04) Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

Individuals and families eligible to receive Medicaid in these coverage groups are subject to the MAGI standard for determining income eligibility beginning January 1, 2014 and, if eligible, at annual renewals thereafter.

Excluded Medicaid-eligible Coverage Groups

The rules in this chapter do not apply to:

- Temporary Exemption -- Medicaid members who were determined to be Medicaid eligible prior to January 1, 2014, and are still enrolled for coverage on that date, will not be subject to MAGI-based redeterminations of eligibility until 2015. Any changes in an eligibility factor during the 2014 calendar year will require a MAGI-based redetermination, however.
- ACA Exemption – The ACA excludes certain Medicaid coverage groups from MAGI-based eligibility determinations. These groups are referred to as “Non-MAGI Coverage Groups”

throughout this chapter. The ACA exemption applies to persons who are aged, blind, or with disabilities and eligible under MCAR sections 0582 or in need of long-term services and supports (LTSS) under the eligibility requirements in MCAR 0376. The exemption also extends to individuals who qualify for Medicaid based on their eligibility for another publicly funded program, such as children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Payment Program.

Special Provisions

MCAR section 1315 applies exclusively to parents/caretakers with income between 133% and 175 % of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended). All other rules in this chapter do not apply.

1300.04 The Medicaid Single State Agency –

RI Executive Office of Health and Human Services (EOHHS)

Rhode Island General Laws section 42-7.2-2 created the Rhode Island Executive Office of Health and Human Services (EOHHS) in 2006. EOHHS sits within the executive branch of State government and serves “as the principal agency of the executive branch of state government for managing the departments of children, youth and families, health, human services, and behavioral healthcare, developmental disabilities and hospitals.”

The EOHHS is designated as the “single state agency”, authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq.*), and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program. The agency is headed by a Secretary, appointed by the Governor with the advice and consent of the Senate.

01. General Duties -- The EOHHS has been delegated the following duties and responsibilities in leading the State's four (4) health and human services departments in order to:
 - Improve the economy, efficiency, coordination, and quality of health and human services policy and planning, budgeting and financing;
 - Design strategies and implement best practices that foster service access, consumer safety and positive outcomes;
 - Maximize and leverage funds from all available public and private sources, including federal financial participation, grants and awards;
 - Increase public confidence by conducting independent reviews of health and human services issues in order to promote accountability and coordination across departments;
 - Ensure that State health and human services policies and programs are responsive to changing consumer needs and to the network of community providers that deliver assistive services and supports on their behalf. (See Rhode Island General Laws section 42-7.2-2 *et seq.*).

The four state agencies under EOHHS possess and maintain the legal authority to execute their respective powers and duties in accordance with their statutory authority.

02. Single State Agency – In its capacity as the Single State Agency, the responsibilities of the EOHHS are as follows:

(01) Federal law and regulations. As the designated Single State Agency, federal law and regulations, the EOHHS must:

- Administer or supervise the administration of the Medicaid program in accordance with the Medicaid State Plan;
- Maintain sole authority for the promulgation of rules governing the administration of the State Plan that are binding on the EOHHS and any entities delegated with the responsibility to administer any facet of the program;
- Assure eligibility determinations are performed in accordance with all applicable State Plan requirements and federal and State laws and rules and regulations whether performed by the EOHHS or another public agency approved in the State Plan to serve this purpose;
- Determine which providers are “certified” as qualified to furnish Medicaid covered benefits;
- Establish the rates and methods for making payment to certified providers who deliver covered benefits;
- Administer a system for collecting and paying claims in a timely manner;
- Assure the quality of care provided to Medicaid members;
- Institute control mechanisms designed to minimize improper payments resulting from unintended errors, as well as fraud and abuse; and
- Provide a system for resolving grievances by applicants, beneficiaries, and providers.

(02) State law and regulations. In addition to the responsibilities of the Medicaid agency set forth in federal law and regulations, Secretary of EOHHS, as the chief executive of the Medicaid Single State Agency, has the following duties:

- Coordinate the administration and finance of Medicaid-funded benefits and services provided under the Medicaid State Plan and the State’s Medicaid Section 1115 demonstration waiver;
- Serve as the Governor's chief advisor and liaison to federal policymakers on Medicaid reform issues as well as the principal point of contact in the state on any such related matters.

- Review any Medicaid State Plan amendments, waiver extensions, amendments or requests, and initiatives requiring Medicaid funding to assess their overall impact and to ensure they are legally and fiscally sound and in the best interest of consumers,
 - Prepare an annual Medicaid expenditures report;
 - Develop and submit an integrated Medicaid budget; and
 - Ensure Medicaid program quality and integrity.
03. Agency organization -- The EOHHS is organized into five units, each of which focuses on one of the agency's core functions: Office of the Secretary, Financial Management, Policy and Innovation, Legal Services, Program Integrity and Publicly Financed Health Care (Medicaid). The units work in collaboration with one another and with the leadership of the departments to achieve greater efficiency in the organization, finance, design and delivery of services.
04. Medicaid programs and operations – The Medicaid program is located in the Office of Publicly Financed Health Care and operates under the general supervision of the Secretary of EOHHS. The Department of Human Services (DHS) has been designated through an interagency agreement with the EOHHS to perform eligibility determinations for Medicaid-eligible adults who are aged, blind or disabled as well as persons seeking Medicaid-funded long term services and supports. The DHS also is responsible for providing assistance to individuals and families applying for Medicaid in the Medicaid Affordable Care Coverage (MACC) groups identified in MCAR section 1301. A full description of the Medicaid program and the responsibilities of the EOHHS, and its designees, in the organization, finance and delivery of services are located on the agency website at: www.eohhs.ri.gov.

1300.05 The Medicaid Section 1115 Waiver

The EOHHS is the principal agency with responsibility for implementing the Rhode Island's Section 1115 demonstration waiver (formerly the Global Consumer Choice Compact Waiver). The waiver gives the State the authority to make changes in Medicaid requirements to pursue initiatives that promote the goals. The EOHHS has used the flexibility the waiver affords the State to:

- Continue efforts to re-balance the system of long term services and supports by assisting people in obtaining care in the most appropriate and least restrictive setting;
- Achieve greater utilization of care management models that offer a health home and provide an integrated system of services;
- Use smart payment and purchasing strategies that encourage and reward quality outcomes to finance and support Medicaid initiatives that fill gaps in the integrated system of care; and
- Recognize and assure access to the non-medical services and supports, such as peer navigation and employment and housing stabilization services that are essential for optimizing a person's health, wellness and safety and reducing or delaying the need for long term services and supports.

The Section 1115 waiver also provides the EOHHS with the authority to obtain federal matching funds for Medicaid services to individuals who are at risk of becoming eligible for high cost long term care.

1300.06 EOHHS and ACA Implementation

The EOHHS is responsible for implementing the program expansions the State has elected to pursue under the ACA as well as working with the Lieutenant Governor’s Task Force and other State agencies, offices and departments that have been involved in establishing the affordable care eligibility system. Additionally, the EOHHS has been collaborating with the departments to expand the capacity of the eligibility system to include other health and human services programs and to explore opportunities under the ACA to support this effort and other initiatives that improve health care quality, access and affordability for eligible Rhode Islanders.

Every unit within the EOHHS has been involved to some degree in performing these and other tasks related to the implementation of the ACA. Principal duties of the EOHHS include collaboration, as appropriate, with other State agencies in:

- Developing ACA-related changes in policies, procedures and rules;
- Preparation and submission of State Plan and Section 1115 waiver amendments;
- Coordinating application and eligibility procedures for affordable coverage;
- Providing the public with adequate notice and the opportunity for comment on ACA-related changes in policies, rules, procedures and State Plan and Section 1115 waiver amendments;
- Assuring easy access to Medicaid coverage by implementing a “No Wrong Door” policy;
- Instituting a state-wide readily accessible Contact Center to facilitate ease of application, enrollment and renewal;
- Offering consumers the help of highly trained Navigators and personal assistants to guide them through the application process; and
- Ensuring there are adequate resources to sustain ACA-related innovations and reforms.

1300.07 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.

1300.08 One Application, No Wrong Door, Medicaid First

- One application --The State's affordable care system uses one streamlined application to evaluate eligibility for all types of coverage, including Medicaid.
- No Wrong Door -- Applicants can apply on-line on their own through links on the EOHHS and DHS websites or HealthSourceRI.com, or with the assistance of a Navigator, or DHS agency or Contact Center representative. Applications are accepted through the web-portal, in person at the Contact Center and DHS field offices and by mail and telephone.

- Medicaid First -- Once an application is submitted, the system tests for Medicaid eligibility first. If an applicant is found ineligible for Medicaid, the system applies the eligibility rules for federal premium tax credits, cost-sharing reductions and other subsidies. When no forms of assistance apply, the applicant still has the option to shop for a qualified health plan through HealthSourceRI that meets the applicant's coverage needs.

1300.09 Outreach and Enrollment Support Program: Assistors and Navigators

The ACA requires state-based exchanges to establish a navigator program to assist prospective enrollees with understanding the availability of coverage through the Exchange; the availability of federal premium tax credits and cost-sharing subsidies; and eligibility for Medicaid. Rhode Island's Outreach and Enrollment Support Program (OESP) includes both navigators and in-person assistors.

01. Navigators --The functions of Navigators include:

- Conduct public education activities to raise awareness of the availability of QHPs;
- Distribute fair and impartial information concerning enrollment in QHPs, and the availability of premium tax credits and cost-sharing reductions;
- Facilitate enrollment in QHPs;
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or determination under such plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

02. In-person Assistors -- In addition to navigators, guidance issued in July 2012 by the federal Center for Consumer Information and Insurance Oversight (CCIIO), permits states to utilize in-person assistors (IPAs) to extend the reach of the OESP, particularly in the initial 18 months of outreach and education when enrollment needs are expected to peak. In Rhode Island, the role of an in-person assistor generally mirrors that of a navigator.

1300.10 Contact Center

As a federal requirement in the implementation of the Affordable Care Act (ACA), the State must provide consumers assistance with enrollment into affordable health insurance. To meet this requirement, Rhode Island engaged the services of a professional "call center" to handle inbound calls, make outbound calls, and engage Rhode Islanders who need assistance applying for or enrolling in affordable health coverage. The Contact Center supports both HealthSourceRI and EOHHS, in its role as the Medicaid State Agency and is open seven (7) days a week, from 8:00 am-9:00 pm Monday-Saturday and 12:00-6:00 on Sunday. The phone number is [855-840-4774](tel:855-840-4774). Customers can call at [\(855\) 840-4774](tel:855-840-4774) or come to the Walk-In Center for in-person assistance at 70 Royal Little Drive in Providence. The Contact Center is prepared to answer a variety of questions ranging from health care basics, product and benefit information, cost and how to enroll in coverage.

1300.11 HealthSourceRI

HealthSourceRI (HSRI) is the State's health insurance marketplace created in conjunction with implementation of the ACA. HSRI uses the same affordable coverage eligibility system as Medicaid. As such, applicants who apply through HSRI will be tested for Medicaid eligibility as well as for federal premium tax credits, cost-sharing reductions and any other subsidies that might apply. HSRI also serves as health insurance market for small businesses and individuals and families who do not qualify for help paying for coverage.

- To apply for affordable coverage on-line, healthsourceri.com
- To enroll, or talk to an expert, call **1-855-840-HSRI (4774)**.
- To meet with an expert for a free consultation, visit the Contact Center at **70 Royal Little Drive Providence, RI 02904**
- For all other inquiries, contact the Administrative Offices at **RI State House, Room 124 Providence, RI 02903**
- Administrative Offices phone number: **401-222-5194**.

1300.12 For Further Information or to Obtain Assistance

Applications for affordable coverage are available online on the following websites:

- www.eohhs.ri.gov
- www.dhs.ri.gov
- www.HealthSourceRI.com

Applicants may also apply in person at one of the Department of Human Services offices and the Contact Center or by telephone, fax or the U.S. Mail. Request an application by calling 1-855-447-7747

1300.13 Severability

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.