



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 2:00 p.m. | Tuesday, December 3, 2013 6:00 p.m. |
| Arnold Conference Center 111 Howard Avenue Regan Building Pastore Complex Cranston RI 02920 | DaVinci Center 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.

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.

Draft Rule: For Public Comment

State of Rhode Island and Providence Plantations
Executive Office of Health & Human Services



Access to Medicaid Coverage Under the Affordable Care Act

Section 1312:

Rite Share Premium Assistance Program

October 2013 (Proposed)

Rhode Island Executive Office of Health and Human Services
Access to Medicaid Coverage Under the Affordable Care Act
Rules and Regulations Section 1312:
RIte Share Premium Assistance Program

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1312 of the Medicaid Code of Administrative Rules entitled, “RIte Share Premium Assistance Program”** 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.

1312 RIte Share Premium Assistance Program

1312.01 Overview

Under the terms of Section 1906 of Title XIX of the U.S. Social Security Act, states are permitted to pay an eligible individual's share of the costs for enrolling in employer sponsored health insurance coverage if it is cost effective to do so. R.I.G.L. 40-8.4-12 authorized the Medicaid agency to establish the RIte Share Premium Assistance Program to subsidize the costs of enrolling Medicaid eligible individuals and families in employer sponsored health insurance (ESI) plans that have been approved as meeting certain cost and coverage requirements. The Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, uses cost-effective criteria to determine whether ESI plans meet these requirements.

1312.02 Scope and Purpose

This section applies to individuals and families determined to be Medicaid eligible under section 1301 (Medicaid Affordable Care Coverage “MACC” groups). It also applies to specified individuals determined to be Medicaid eligible under section 1309 (non-MAGI or non-Medicaid funded). If these individuals or families have access to insurance provided through an employer (ESI), the Medicaid agency must conduct a review of the coverage to determine if the benefits are comparable to Medicaid benefits and if the cost of the ESI is less expensive than full Medicaid coverage. When ESI is found to be cost-effective, the State will pay the employee’s premium.

The purpose of this rule is to set forth the provisions governing participation in the RIte Share program, the buy-in requirement and the process for determining whether an ESI plan meets the cost-effectiveness criteria established by the EOHHS, the Medicaid agency. The rule also identifies the respective roles and responsibilities of Medicaid eligible individuals and families and the Medicaid agency.

1312.03 Definitions

For the purposes of this section, the following definitions apply:

“**Cost-effective**” means that the portion of the ESI that the State would subsidize, as well as wrap-around costs, would, on average, cost less to the State than enrolling that same individual/family in a managed care delivery system.

“**Cost sharing**” means any co-payments, deductibles or co-insurance associated with ESI.

“**Employee Premium**” means the monthly premium share an individual or family is required to pay to the employer to obtain and maintain ESI coverage.

“**Employer-Sponsored Insurance or ESI**” means health insurance or a group health plan offered to employees by an employer. This includes plans purchased by small employers through HealthSourceRI.

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“Group health plan” means an employee welfare benefits plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 as qualified in R.I.G.L. 27-50-3(T)(1) and 27-18.6-2(15).

“Health insurance coverage or health benefit plan” means a policy, contract, certificate or agreement offered by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services as defined and qualified in R.I.G.L. 27-18.5-2(7), 27-18.6-2(14) and 27-50-3(U)(1).

“Medicaid member” means a person who has been determined to be an eligible Medicaid beneficiary

“Modified Adjusted Gross Income or (MAGI)” means income, adjusted by any amount excluded from gross income under section 911 of the IRS Code, and any interest accrued. Social Security benefits are not included in gross income. The MAGI is the standard for determining income eligibility for all Medicaid affordable care coverage groups (MCAR section 1301).

“New Applicant” means an individual or family that was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date this rule. The term does not apply to individual and families who were receiving coverage and where disenrolled for any reason; nor does it apply to parents with income between from 133% to 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).

“Policy holder” means the employee with access to ESI.

“RIte Share-approved employer-sponsored insurance (ESI)” means an employer-sponsored health insurance plan that meets the coverage and cost-effectiveness criteria for RIte Share.

“RIte Share buy-in” means the monthly amount the parent/caretaker of a Medicaid-eligible child must pay toward RIte Share-approved ESI when household income based on the MAGI is above 150% of the FPL.

“RIte Share premium assistance program” means the Rhode Island Medicaid premium assistance program in which the State pays the eligible Medicaid member’s share of the cost of enrolling in a RIte Share-approved ESI plan. This allows the State to share the cost of the health insurance coverage with the employer.

“RIte Share Unit” means the entity within EOHHS responsible for assessing the cost-effectiveness of ESI, contacting employers about ESI as appropriate, initiating the RIte Share enrollment and disenrollment process, handling member communications, and managing the overall operations of the RIte Share program.

“RIWorks” means the State’s Temporary Assistance for Needy Families (TANF) program that provides assistance to low income needy families on the path to full employment and financial independence. The program is administered by the Rhode Island Department of Human Services, one of the four State agencies under the Executive Office of Health and Human Services (EOHHS) agenda.

“Third Party Liability (TPL)” means other health insurance coverage. This insurance is in addition to Medicaid and is usually provided through an employer. Since Medicaid is always payer of last resort, the TPL is always the primary coverage.

“Wrap-around services or coverage” means any health care services not included in the ESI plan that would have been covered had the Medicaid member been enrolled in a RItE Care (MCAR 1309) or Rhody Health Partners (MCAR section 1310) plan. Coverage of deductibles and co-insurance is included in the wrap. Co-payments to providers are not covered.

1312.04 RItE Share Populations

The income of Medicaid members affects whether and in what manner they must participate in RItE Share as follows:

01. Income at or below 150% of FPL -- Individuals and families determined to have household income at or below 150% of the Federal Poverty Level (FPL) based on the modified adjusted gross income (MAGI) standard -- in accordance with MCAR section 1307 – are required to participate in RItE Share if a Medicaid-eligible adults or parent/caretaker has access to cost-effective ESI. Enrolling in ESI through RItE Share is a condition of maintaining Medicaid eligibility. The buy-in requirement described in section 1312.07 does not apply, however.
02. Income above 150% of the FPL -- Individuals and families determined to have income above 150% of the FPL using the MAGI standard are required to participate in RItE Share if a Medicaid- eligible adult or parent/caretaker has access to cost-effective ESI. Enrolling in ESI through RItE Share is also a condition of maintaining Medicaid eligibility. The buy-in requirement described in section 1312.07 applies.
03. Policy holder Is Not Medicaid-Eligible -- Premium assistance is available when the household includes Medicaid-eligible members, but the ESI policy holder is not eligible for Medicaid. Premium assistance for parents/caretakers and other household members who are not Medicaid eligible is provided when:
 - (01) Enrollment of the Medicaid-eligible family members in the approved ESI plan is contingent upon enrollment of the ineligible policy holder; and
 - (02) It is cost-effective to provide a subsidy to family coverage compared to the cost of enrolling Medicaid eligible family members in a Medicaid managed care plan, using methodology described in section 1312.08.

1312.05 RItE Share Enrollment as a Condition of Eligibility

For Medicaid members over the age of nineteen (19), enrollment in RItE Share is a condition of eligibility. This requirement also applies to any individuals who have or previously had the option to waive ESI coverage to receive financial compensation, including but not limited to, an increase in hourly wage, an increase in weekly salary, and/or a lump sum payment. (An increase in wages for waiving coverage is also known as "pay in lieu of benefits.")

01. Exemptions – In certain circumstances, Medicaid members with access to ESI are exempt from enrolling as condition of maintaining eligibility:

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- (01) Non-Citizen policy holder. RIte Share enrollment is not required if the employed parent/caretaker in the household with ESI is a non-citizen ineligible for Medicaid due to immigration status.
 - (02) Under age 19. Medicaid-eligible children and young adults up to age nineteen (19) are not required to enroll in a parent/caretaker relative's ESI as a condition of maintaining Medicaid eligibility.
 - (03) RIWorks. There is a limited six (6) month exemption from the mandatory enrollment requirement for RIWorks program participants. See section 1312.05 below.
02. Mandatory ESI Enrollment -- Once it has been determined by the Medicaid agency that the ESI offered by a particular employer is RIte Share-approved, all Medicaid members with access to that employer's plan are required participate in RIte Share. If the policy holder (i.e., employee) in the household is a Medicaid-eligible parent/caretaker age nineteen (19) or older, the policy holder is responsible for enrolling any Medicaid-eligible family members (i.e., spouse, caretaker, and children) in the RIte Share-approved ESI plan.
03. Non-compliance – Failure to meet the mandatory enrollment requirement results in the termination of the Medicaid eligibility of the policy holder and other Medicaid members nineteen (19) or older in the household that could be covered under the ESI until the policy holder complies with the RIte Share participation and enrollment procedures established by the Medicaid agency in this rule. (See section 1312.20).
04. Reinstatement – The period of ineligibility may be shortened and Medicaid eligibility reinstated if participation in RIte Share by the policy holder is no longer required either due to a change in the status of the ESI (e.g., the employer's plan is no longer RIte Share-approved) or access to the employer's plan (e.g., the policy holder changes jobs or is no longer qualified for ESI as a result of a decrease in work hours).

1312.06 Rhode Island Works Participants

RIWorks participants who are Medicaid-eligible are not required to enroll in a RIte Share-approved ESI plan for the first six (6) months of employment. This six month exemption also applies to families losing eligibility for RIWorks due to employment. Specifically, to be subject to enrollment in a RIte Share approved ESI plan, the RIWorks participant must be:

- Age nineteen (19) or older; and
- Employed for a period of six (6) consecutive months or more by the same employer.

RIWorks participants who do not meet both of these criteria at the time Medicaid eligibility is renewed in accordance with section 1312.16.01 are exempt from participating in RIte Share.

1312.07 RIte Share Premium Assistance

Under the RIte Share Premium Assistance Program, the State pays the policy holder's premium. In some cases, the State will also pay for cost-sharing requirements. Medicaid members also receive wrap-around services.

01. Premium payments – The Medicaid agency pays for ESI premiums as follows:

- The Medicaid agency pays the premium the policy holder must pay to the employer for ESI for his or her own individual coverage (e.g., parent/caretaker who is pregnant women).
- The Medicaid agency pays the premium the policy holder must pay to the employer for ESI for family/dependent coverage. See section 1312.17.

02. Cost-sharing --Medicaid members enrolled in ESI are not obligated to pay any cost-sharing that is not otherwise applicable to Medicaid. The Medicaid agency pays for any ESI co-insurance and deductibles in such instances. Co-pays are not covered by the Medicaid agency, but RIte Share enrollees are not required to pay co-payments to Medicaid certified providers. The health care provider may not bill the RIte Share member for any cost-sharing required by the ESI, including co-payments.

03. Wrap-around Coverage --Services and benefits that are covered by Medicaid, but are not offered through the ESI plan, are made available through the Medicaid program. Wrap-around services/coverage ensures that RIte Share enrollees receive health coverage comparable in scope, amount and duration to Medicaid members enrolled in RIte Care or Rhody Health Partners. Medicaid covers these services for Medicaid members participating in RIte Share enrollees when using Medicaid providers.

04. Repayment and recoupment -- EOHHS has the authority to recover Medicaid benefit overpayment claims and cost share arrearages through offset of the individual State income tax refund in accordance with Section 44-30.1-1, 44-30.1-3, 44-30.1-4 and 44-30.1-8 of the Rhode Island General Laws in Chapter 44-30.1 entitled 'Setoff of Refund of Personal Income Tax.' An example of a benefit overpayment is a premium payment made to a policy holder for ESI that was not active during the month(s) for which the payment was made.

1312.08 RIte Share Buy-in Requirement

In certain instances, Medicaid members participating in RIte Share are subject to a buy-in requirement. This requirement applies only when a Medicaid-eligible child residing in a household with MAGI-based income above 150% of the FPL must enroll in the RIte Share-approved ESI plan of a parent/caretaker.

01. Buy-in amount -- The parent/caretaker is required to pay a monthly buy-in amount that varies with income as follows:

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| Monthly Family Income | Monthly Buy-In Amount |
|---|------------------------------|
| Over 150% and not greater than 185% FPL | \$ 61.00 |
| Over 185% and not greater than 200% FPL | \$ 77.00 |
| Over 200% and not greater than 250% FPL | \$ 92.00 |

02. Notice – The Medicaid agency must provide the Medicaid member subject to the buy-in requirement with timely notice. This may be done separately or in conjunction with the notice of RItE Share participation. The notice must include the amount of the buy-in, the process for making payments, the consequences for non-payment and a statement of the right to appeal and request a hearing.
03. Payment -- Buy-in amounts are not prorated. Therefore, a full monthly buy-in amount is due if RItE Share enrollment is effective for any portion of a coverage month.
04. Method of payment -- The parent/caretaker pays the monthly RItE Share buy-in amount to the Medicaid agency. Further information about the payment method is provided in the notice of the buy-in requirement sent to the parent/caretaker.
04. Non-compliance – If the parent/caretaker fails to pay the buy-in amount as required, eligibility may be terminated for failing to cooperate in accordance with section 1312.22.

1312.09 Basis for Approving of ESI Plans

Only ESI or group health plans that meet the cost-effectiveness and benefits criteria specified in this section are approved for the RItE Share premium assistance program.

01. Sources of information for determining cost-effectiveness -- Determinations of ESI cost effectiveness on information gathered from the following sources:
 - (01) Application materials. When applying for Medicaid, applicants must indicate: current health insurance coverage status; relationship to policy holder; plan name; policy number; eligibility for and type of coverage (e.g., individual, family, individual and single dependent); employee costs for coverage (e.g., employee's share for individual v. family/dependent coverage); and individuals covered by plan. MCAR section 1303 explains the process for applying for Medicaid through the State's affordable care eligibility system and the manner in which this information is collected and maintained.
 - (02) The RItE Share Unit. This Unit of the Medicaid agency collects data about ESI plans of the employers of Medicaid- eligible individuals/households. Information from employers includes data necessary to determine whether the employer's ESI offerings meet the Medicaid agency's cost-effectiveness and benefits criteria.
02. EOHHS reserves the right to request additional information about the ESI plan from the Medicaid member, the policy holder, even if not an eligible Medicaid member and, where appropriate and necessary, the employer or insurance carrier.

1312.10 Methodology for Determining Cost-Effectiveness

The RItE Share Unit uses the information about the ESI plan to compare the enrollment cost (i.e., payment of the employee's share) for the Medicaid members in the family, and any ineligible policy holder, in a Medicaid managed care plan versus RItE Share. An ESI plan is determined to be cost effective when on the aggregate, the total cost of Medical coverage through RItE Share is less than the average cost to cover them through a Medicaid managed care plan. RItE Share participants receive coverage comparable in scope, amount and duration to coverage provided in a Medicaid managed care plan.

01. Cost-effectiveness test -- To be cost-effective, the policy holder's monthly ESI premium share, deductibles, co-insurance plus any Medicaid covered services not covered by the ESI plan (e.g., services covered under the RItE Care Health Plan contract but not under the ESI plan) must be less than the average capitation payment for an average individual/family enrolled in a Medicaid managed care plan. These average costs must be actuarially determined at such intervals as deemed appropriate by EOHHS.
02. There are three cost effectiveness determinations for each employer plan:
 - (01) Family coverage where all family members are Medicaid-eligible with income less than or equal to 133% of the FPL based on the MAGI standard;
 - (02) Family coverage where only children and pregnant women in the family are Medicaid eligible with income greater than 133% of the FPL and less than or equal to 250% of the FPL based on the MAGI standard; and
 - (03) Individual coverage where only the employee is Medicaid-eligible (e.g., pregnant women).

The figures used as the basis for assessing cost effectiveness shall be made available, upon request, by EOHHS.

1312.11 Scope and Consequence of Approving an ESI Plan

RItE Share-approved ESI plans are reevaluated on an annual basis to ensure that all Medicaid members who are enrolled receive coverage comparable in scope, amount and duration to that provided in a Medicaid managed care plan. From the date an ESI plan is approved until the date it is reevaluated, any Medicaid members who work for that employer and their Medicaid-eligible dependents must enroll in the ESI through RItE Share. Parents/caretakers of a Medicaid-eligible child who have access to a RItE Share-approved ESI plan must enroll the child in the employer plan irrespective of their own Medicaid eligibility. In either case, failure of the parent/caretaker to enroll in the RItE Share-approved plan does not affect the eligibility of the child.

1312.12 Enrollment Process

Medicaid members who are required to participate in RItE Share must enroll in the ESI plan as directed by the Medicaid agency. Enrollment into RItE Share may occur upon initial determination at the time of annual renewal, or as deemed appropriate by the EOHHS.

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01. Eligibility determination and RItE Share referral – The referral for RItE Share participation is based on information provided by the Medicaid member in conjunction with an application or annual renewal; and documented in the RItE Share database as to whether an employer offers RItE Share-approved coverage.
02. Notice RItE Share participation required – The notice that participation in RItE Share is a condition of retaining Medicaid eligibility must be sent by EOHHS as follows:
 - (01) Fourteen days notice. Upon determining that a Medicaid member is qualified for coverage through RItE Share, EOHHS provides a written Notification of Eligibility for Enrollment stating the employee must select a RItE Share-approved ESI plan through their employer's personnel or human resources office within fourteen (14) calendar days.
 - (02) Thirty days notice. Written notice will be sent to the Medicaid recipient approximately thirty (30) days prior to the date that enrollment in RItE Share is required, but only in instances when approval of the ESI plan is the impetus for the requirement to enroll rather than a determination/renewal of Medicaid eligibility; and the employer is not participating in RItE Share.
03. Prior agreement – In certain circumstances, EOHHS may have a prior agreement with the employer which permits the RItE Share Unit to enroll an eligible individual/family in the ESI plan upon receipt of an acknowledgment or written consent from the policy holder. The notification of enrollment sent from the RItE Share Unit to the Medicaid ineligible policy holder as well as to any Medicaid recipients in such cases shall explain any such prior arrangements and any additional appeal and hearing rights that follow therefrom.

1312.13 Access to ESI

All Medicaid applicants and members are required to provide information about access to ESI. For the purposes of RItE Share, “access” to ESI is as follows:

- A Medicaid-eligible individual, age nineteen (19) or older who is, or has the option to be, enrolled in an employer-sponsored health insurance or group health benefit plan;
- A Medicaid-eligible individual who is, or has the option to be, enrolled in an employer-sponsored health insurance or group health benefit plan as the spouse, dependent or family member of a Medicaid-ineligible policy holder.

Failure to provide this information as required may lead to the denial or termination of Medicaid eligibility, unless there is good cause for non-compliance as specified in section 1312.23.

1312.14 Non-custodial Parents with TPL

Medicaid is always the payer of last resort. Accordingly, the Medicaid agency considers all other health insurance or coverage provided to a Medicaid-eligible individual as third-party liability (TPL) coverage. EOHHS reserves the right to require Medicaid members to transition to the TPL coverage in instances it meets the cost and coverage effectiveness criteria for RItE Share. Special rules for

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handling this transition when a parent who does not have custody of the Medicaid-eligible child has access to ESI or other TPL are as follows:

01. TPL Coverage through the non-custodial parent -- Children who are enrolled in both RItE Care and ESI through a non-custodial parent (NCP), will be transitioned into RItE Share unless the custodial parent shows good cause for not making the transition. Once enrolled in TPL coverage, the child must retain access to all applicable Medicaid covered services the entire time that they are in RItE Share. Should the NCP lose their ESI, the RItE Share Unit must be notified at least ten (10) days prior to the child's disenrollment to meet established reporting requirements and assure the child is transitioned back into RItE Care without coverage gaps.
02. Custodial parent non-compliance -- If the custodial parent refuses to allow the child to be enrolled in the NCP's ESI or TPL coverage more generally, then the custodial parent's Medicaid eligibility is terminated until the parent complies with the RItE Share participation requirement. Good cause exemptions to RItE Share are permitted under section 1312.23.
03. Notice and enrollment – Medicaid members who are potential candidates for RItE Share must be provided with notice from the Medicaid agency letter explaining their rights and responsibilities including:
 - (01) RItE Share participation. The requirement to participate in RItE Share is a condition of Medicaid eligibility for adults in the household. The Medicaid member with TPL must be receive the notice fourteen (14) or thirty (30) days, as appropriate (see section 1312.11.02), prior to the required transition from a Medicaid managed care plan.
 - (02) Grace period. Parents/caretakers are given a fourteen (14) day grace period to report any changes in the NCP's coverage and/or report any difficulties with using the NCP's coverage.
 - (03) Failure to respond. If the parent/caretaker does not respond, the Medicaid members who are covered under the NCP's policy will be transitioned from RItE Care to RItE Share, and sent appropriate documentation. Those who are not covered under the NCP's coverage (e.g., custodial mom, children not related to the NCP) will remain on RItE Care.
 - (04) Cost-sharing. The notification must indicate clearly that the Medicaid agency will not make payment for coinsurance, cost sharing obligations, or wrap-around coverage to or for the NCP policy holder or any other Medicaid-ineligible family member/dependent enrolled in the approved ESI plan.
 - (05) Buy-in. If income is above 150% of the FPL, the notice must state the basis for the buy-in and the amount that must be paid per month in accordance with section 1312.07 and the consequences for non-compliance in section 1312.22.

1312.15 Continuing Eligibility – Renewals

For Medicaid members renewing eligibility, the Medicaid agency must assess as part of the redetermination process whether anyone in the household is a RItE Share participant and if there has been any change in access to ESI.

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01. Notice of renewal – Medicaid members must be provided with a notice at the time of renewal specifying the terms for continuing eligibility. The terms for continuing coverage vary as follows:
 - (01) Medicaid managed care enrollees without access to ESI continue enrollment in the Medicaid managed care plan that provided coverage in the previous period of eligibility in accordance with MCAR section 1311.
 - (02) Medicaid managed care enrollees who have gained access to a RItE Share-approved ESI plan continue to be enrolled in the Medicaid managed care plan that provided coverage in the previous period of eligibility pending review by the RItE Share Unit. In such cases, EOHHS sends a notice stating that eligibility is continued and that coverage in a Medicaid managed care plan continues pending action on the ESI plan by the RItE Share Unit. A referral to the RItE Share Unit is made accordingly.
 - (03) RItE Share participants who retain access to the RItE Share-approved ESI plan that provided coverage during the previous period of eligibility, continue to be enrolled in the ESI plan pending review by the RItE Share Unit of any changes that might result in withdrawal of approval of the ESI plan, disenrollment, and subsequent enrollment in a Medicaid managed care plan.
02. Loss of ESI -- RItE Share participants who involuntarily lose access to an approved ESI plan that provided coverage during the previous period of eligibility for any of the reasons stated in 1312.21.02 receive coverage as follows:
 - (01) If the ESI plan is a Medicaid managed care plan, and the involuntary disenrollment occurred in the ninety (90) day period prior to and inclusive of the renewal date, the Medicaid-eligible family members must be enrolled in a Medicaid managed care plan according to the enrollment procedures set forth in MCAR section 1311.
 - (02) If the ESI plan is not a Medicaid managed care plan, any Medicaid-eligible individuals in the family receive coverage through fee-for-service pending either enrollment in a Medicaid managed care plan, or if the Medicaid members have gained access to another ESI plan, approval of that plan by the RItE Share Unit.
03. Notice of renewal -- In all such cases, the notice of renewal for continuing eligibility sent by EOHHS to the Medicaid members shall include a statement of the applicable terms for continuing eligibility including any buy-in requirement, the reason(s) for establishing the terms, and the right to appeal and request a hearing with respect to either (See MCAR section 0110), as well as all other information required in this section. The enrollment referral transmitted to the RItE Share Unit shall also indicate which terms apply and shall be sent at the time the redetermination is made.

1312.16 Renewal of RIWorks Participants

At the time eligibility renewals are completed, EOHHS is responsible for assessing whether RIWorks participants are subject to enroll in a RItE Share-approved plan as a condition of Medicaid eligibility.

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01. Employed under 6 months -- Only those RIWorks participants, age nineteen (19) and over, who have access to ESI and have been steadily employed for a period of six (6) consecutive months or more, shall be subject to enrollment in RIte Share. All other RIWorks participants continue enrollment in the RIte Care plan which provided coverage until the next scheduled redetermination of eligibility.
02. Employed 6 months or over -- If the RIWorks participant has been employed for over six (6) months, the notice of renewal sent by the Medicaid agency must state that enrollment in the RIte Care plan that provided coverage during the previous period of eligibility is continued, pending review of the ESI plan by the RIte Share Unit. The Medicaid members shall receive notice from the RIte Share Unit at least fourteen (14) days prior to enrollment in an ESI plan if enrollment in an approved ESI plan is a condition of retaining continuing eligibility.

1312.17 RIte Share Premium Assistance Payment

It is the responsibility of EOHHS to establish the appropriate mechanism for transferring payment for the RIte Share-approved ESI plan premiums.

01. The payment options include:
 - (01) Enrollment costs are paid directly by the employer without any wage withholding from the policy holder. The RIte Share Unit or its agent either mails a check or electronically transfers payment to the employer's bank or account, on a monthly basis, to cover the enrollment costs for any individuals/families on the ESI as a result of RIte Share enrollment. These are called "participating" employers
 - (02) Enrollment costs are paid by the employer after wage withholding from the policy holder. The RIte Share Unit or its agent mails a check or electronically transfers payment to the policy holder, on a monthly basis, to cover the enrollment costs for any individuals/families on ESI as a result of RIte Share enrollment.
 - (03) Enrollment costs (both the employer's premium share and the employee's premium share or employee's premium share only) are paid directly to the insurance carrier on a monthly basis by the RIte Share Unit or its agent. (If both the employer and employee enrollment costs are paid, EOHHS then bills the employer for the employee's enrollment costs).
02. Notice of payment method --The notification of RIte Share participation sent to the recipient(s) shall clearly specify the method for paying enrollment costs.

1312.18 Role of RIte Share Unit

The RIte Share Unit is responsible for overseeing the operations of the program as follows:

- Eliciting information from RI employers about the health plans they offer to workers on an ongoing basis.
- Evaluating health plans for RIte Share approval.

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- Maintaining a database of RItE Share-approved ESI plans; and
- Contacting employers to make RItE Share enrollment decisions.

Upon receipt of member referral information, the RItE Share Unit verifies employment and access to a RItE Share-approved ESI plan. Based on this review, the RItE Share Unit determines:

- Whether the Medicaid is approved for RItE Share; and
- The date that individual or family must enroll in the ESI in order to maintain Medicaid eligibility.

The specific procedures for making such determinations vary depending on the enrollment status of the Medicaid members and the employer's customary enrollment process.

1312.19 ESI Enrollment Verification

Verification of enrollment in a RItE Share-approved ESI plan is required.

01. Participating employer -- For Medicaid members working for a RItE Share "participating" employer, the employer is required to submit verification to the RItE Share Unit that initial enrollment in the ESI has been made in the manner prescribed by EOHHS.
02. Approved plan -- For individuals working for a RItE Share-approved employer, the individual must provide verification of enrollment by completing the appropriate form, which requires the signature of a representative of the employer or submitting a copy of the official ESI enrollment receipt. Once this verification has been received, EOHHS will initiate premium payment.

1312.20 Failure to Enroll

Failure to enroll in the ESI plan is grounds for termination of Medicaid eligibility for the parent(s) or caretaker over the age of nineteen (19) in the household. If a Medicaid-eligible policy holder does not enroll as required, a referral is then made by the RItE Share Unit to the appropriate DHS field representative.

01. Discontinuation – The Medicaid agency sends a Notice of Discontinuation, stating that Medicaid eligibility has been terminated for adults in the household due to the failure to enroll in the RItE Share-approved plan. Anyone in the household subject to the notice may reapply (for inactive cases) or request reinstatement (for active Medicaid cases) if they choose to comply with RItE Share, if an exemption from participation is granted, or if the individual no longer has access to the ESI.
02. Disqualification -- Procedures for handling cases in which the policy holder is not eligible for Medicaid are the same as for an eligible policy holder, with one exception: The Medicaid agency sends a Notice of Disqualification to the policy holder indicating that ESI costs will not be paid by EOHHS.

Both the Notice of Discontinuation and the Notice of Disqualification shall include a statement indicating that any affected Medicaid-eligible individuals in the household have the right to appeal and to request a hearing to contest the change in eligibility and the enrollment decision.

1312.21 Disenrollment from RItE Share-Approved Plan

RItE Share participants who are voluntarily or involuntarily disenrolled from an approved ESI plan must report the change in enrollment status to the Medicaid agency in no more than ten (10) days from the date the disenrollment action occurs. The type of disenrollment determines the Medicaid agency's response as follows:

01. Voluntary disenrollment -- Medicaid-eligible RItE Share participants age nineteen (19) and over who voluntarily disenroll from an approved ESI will be terminated for coverage based on the failure to meet the non-financial cooperation requirements set forth in this section. Voluntary disenrollment includes, but is not limited to, instances in which a RItE Share participant:
 - (01) Requests that the employer drop coverage or cease enrollment for the entire family or a Medicaid eligible individual in the family;
 - (02) Fails to meet the requirements established by the employer to maintain enrollment in the approved plan -- e.g., submit required documentation or forms, etc.
 - (03) Engages in unlawful or fraudulent acts, such as submitting false claims that violate the terms for continuing enrollment in the ESI plan.
02. Involuntary disenrollment – Involuntary disenrollment includes the loss of access to ESI as a result of change in employment, termination of coverage by the employer for an entire class of workers, death, separation, divorce, or disability of the policy holder, or any other factors that could be reasonably construed as involuntary disenrollment as defined in this section.
03. RItE Share Unit responsibilities. Upon receiving a report from the employer, the ESI plan insurance provider, or Medicaid member indicating that disenrollment has occurred, the RItE Share Unit verifies the accuracy of the report and assesses whether it is voluntary or involuntary in nature.
 - (01) Voluntary disenrollment – Notice of Discontinuation. Once the report has been verified and it is determined to be voluntary disenrollment, EOHHS sends a Notice of Discontinuance noting termination of the Medicaid eligibility of the policy holder, parent(s) or caretaker relative in the applicant household until the individual demonstrates compliance with enrollment procedures established by EOHHS. The Notice of Discontinuance must also include any remedies for shortening the period of ineligibility as well as the right to request a hearing and appeal the decision
 - Medicaid-ineligible individuals are provided with a notice from the Medicaid agency stating they are disqualified for RItE Share.
 - All Medicaid-eligible pregnant women and children must be automatically enrolled in a RItE Care plan.

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- This period of Medicaid ineligibility may be shortened and Medicaid eligibility established if such individual becomes exempt from RItE Share enrollment or no longer has access to ESI for reasons such as a change in employment. (See sections 1312.21.02).

(02) Involuntary disenrollment. There is no adverse action taken against Medicaid members required to participate in RItE Share if disenrollment from an approved ESI plan is involuntary.

1312.22 Cooperation Requirements

All Medicaid applicants and members must cooperate with the non-financial requirements for eligibility as follows:

01. Information --All individuals and families are required to provide information about other health coverage (TPL) and/or access to ESI when applying for initial or continuing eligibility. The required information relating specifically to access to ESI includes, but is not limited:

- The names of any family members in the household currently covered by or with access to ESI;
- The name of the policy holder and the employer offering the ESI; and
- Verification of monthly enrollment costs via a paycheck stub if the policy holder is currently enrolled or, if available, enrollment information provided by the employer indicating the policy holder's monthly premium for the appropriate family composition.

02. RItE Share participation -- Medicaid members required to enroll in the ESI must cooperate as follows:

- (01) Enroll in the ESI in the manner, and within the time-lines, established by EOHHS. Failure to do so will result in the termination of Medicaid for any eligible parents/caretaker age nineteen (19) and older in the family. The eligibility of any other Medicaid members in a family must not be terminated as the result of the refusal of an otherwise ineligible policy holder to enroll in the ESI. See section 1312.20.
- (02) Submit verification of enrollment in accordance with section 1312.19 when the employer does not participate in RItE Share.
- (03) Provide reports to the Medicaid agency indicating any changes in enrollment status of Medicaid eligible family members, enrollment costs, household composition, employment, income, residence, and access to ESI within ten (10) days from the date the change occurs.
- (04) Pay Buy-in Amounts – Medicaid members subject to the buy-in requirements must cooperate in making monthly buy-in amounts in accordance with section 1312.07 to remain eligible for Medicaid. Failure to make a required premium payment, without

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good cause, as specified in section 1312.23, results in disenrollment from the RItE Share Premium Assistance Program and loss of Medicaid eligibility.

1312.23 Good Cause

EOHHS is responsible for determining whether good cause exists for an exception to the non-financial cooperation requirements for Medicaid eligibility contained in section MCAR 1305 and, more specifically, for participation in RItE Share, except as noted below:

01. Extraordinary circumstances -- EOHHS must exempt a Medicaid member from RItE Share participation only when there are extraordinary circumstances which preclude the individual from receiving medically necessary care through the RItE Share-approved plan. For purposes of this exemption, "extraordinary circumstances" may include:
 - (01) The existence of an unusual and life-threatening medical condition which requires medical treatment that cannot be provided or arranged by the RItE Share plan whether it is provided through the custodial or non-custodial parent;
 - (02) The existence of a chronic, severe medical condition for which the Medicaid member has a long standing treatment relationship for that condition with a provider who does not participate in the RItE Share plan; or
 - (03) Enrollment in the health plan of the non-custodial parent could result in reasonably anticipated physical and/or emotional harm to the child, custodial parent, or other relative with whom the child is living. Claims of physical and/or emotional harm must be determined by the Medicaid agency to be of a genuine and serious nature. The emotional harm to the custodial parent or other relative with whom the child lives must be of such a serious nature that the capacity to care for the child adequately would be reduced.
02. Corroborative evidence – Such evidence supporting a determination of good cause must be supplied to the Medicaid agency. Corroborative evidence may include: court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the non-custodial parent might inflict physical and or emotional harm on the child, custodial parent, or other relative with whom the child lives.
03. Other programs -- If good cause has been granted for any other benefit program administered by EOHHS or DHS, the good cause exemption will be honored by the RItE Share Program.
04. Nature of request -- Enrollment exemptions requested due to extraordinary circumstances must be in writing, with appropriate documentation (letter from physician, medical records, restraining orders, or others as indicated), and signed by the Medicaid member, parent/caretaker or person designated to make the request on their behalf.
05. Basis of the determination -- EOHHS makes RItE Share participation exemption determinations on a case by case basis after considering all required documentation and any other relevant information pertaining to the request. An exemption may be granted for any length of time during the period in which the extraordinary circumstances exist. When an exemption is granted, Medicaid members are enrolled in the appropriate a Medicaid managed care plan in accordance with MCAR section 1311.

06. Limits -- An individual's preference to continue a treatment relationship with a doctor or other health care provider who does not participate in the RIte Share plan does not in and of itself constitute an "extraordinary circumstance."

1312.24 Notice and Appeal Rights

Medicaid applicants and recipients shall receive timely notification of eligibility and enrollment determinations and the right to appeal. EOHHS shall also provide timely notification, including appeal rights, of any adverse decisions that reduce or terminate benefits. See MCAR section 0110 for full statement of these rights.

1312.25 Information

For Further Information or to Obtain Assistance

01. Applications for affordable coverage are available online on the following websites:
 - www.eohhs.ri.gov
 - www.dhs.ri.gov
 - 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).

1312.26 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.