DUPLICATE

STATE Rhode Island

OFFICIAL

1.	In-patient hospital services other than those provided in an insitution for mental disease or tuberculosis	All services for one recipient within a bill
2a.	Out-patient hospital services	All services for one recipient within a bill
2b.	Rural health clinic services and other ambulatory services furnished by a rural health clinic	All services for one recipient within a bill
3.	Other laboratory and x-ray services	All services for one recipient within a bill
4a.	Skilled nursing facility services (other than services in an institution for tuberculosis or mental disease) for individuals 21 years of age or older	A bill of services
4b.	Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found	All services for one recipient within a bill
4c.	Family planning services and supplies for individuals of child-bearing age	All services for one recipient within a bill
5.	Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere	All services for one recipient within a bill
6a.	Podiatrists' services	All services for one recipient within a bill
6b.	Optometrists' services	All services for one recipient within a bill
6c.	Chiropracters' services	Not provided
6d.	Other practitioners' services	All services for one recipient within a bill

R.J. Tr. Incorp. 1/3/80 Effective 10-1-79

OFFICIAL DUPLICATE

STATE Rhode Island

7a.	Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area	All services for one recipient within a bill
7b.	Home health aide services provided by a home health agency	All services for one recipient within a bill
7c.	Medical supplies, equipment and appliances suitable for use in the home	All services for one recipient within a bill
7d.	Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility	All services for one recipient within a bill
8.	Private duty nursing services	Not provided
9.	Clinic services	Not provided
10.	Dental services	All services for one recipient within a bill
11a.	Physical therapy	Not provided
11b.	Occupational therapy	Not provided
11c.	Services for individuals with speech, hearing and language disorders (provided by or under the supervision of a speech pathologist or audiologist)	Not provided
12.	Prescribed drugs, dentures and prosthetic devices; and eye-glasses prescribed by a physician skilled in disease of the eye or by an optometrist	All services for one recipient within a bill

R.L. Tr. Record 1/3/80 Effective 10-1-79

STATE Rhode Island

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12a. Prescribed drugs	All services for one recipient within a bill
12b. Dentures	All services for one recipient within a bill
12c. Prosthetic devices	All services for one recipient within a bill
12d. Eyeglasses	All services for one recipient within a bill
13a. Diagnostic services	Not provided
13b. Screening services	Not provided
13c. Preventive services	Not provided
13d. Rehabilitative services	All services for one recipient within a bill
14. Services for individuals age 65 or older in institutions for mental disease	
a. in-patient hospital services	All services for one recipient within a bill
b. skilled nursing facility services	All services for one recipient within a bill
c. intermediate care facility services	All services for one recipient within a bill
15a. Intermediate care facility	A bill for services
15b. Including such services in a public institution for the mentally retarded or persons with related conditions	A bill for services
16. In-patient psychiatric facility services for individuals under 22	All services for one recipient within a bill
17. Nurse Mid Wife services	All services for one recipient within a bill
18. Hospice services	All services for one recipient within a bill

OFFICIAL

19.	Extended services to pregnant women	All services for one recipient within a bill
20a.	Transportation	All services for one recipient within a bill
20b.	Services of Christian Science Nurses	Not provided
20c.	Care and services provided in Christian Science sanitoria	Not provided
20d.	Skilled nursing facility services for patients under 21 years of age	A bill for services
20e.	Emergency hospital services	Not provided
20f.	Personal care services in recipient's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N.	Not provided
21.	Case Management services	All services for one recipient within a bill

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island

Requirements for Third Party Liability - Identifying Liable Resources

OFFICIAL

FREQUENCY OF DATA EXCHANGES AND TRAUMA CODE EDITS

Presently the Department of Human Services conducts monthly data exchanges with the Social Security Wage and Earnings Files. Additionally, the Department of Human Services conducts monthly data exchanges with the State Department of Employment Security's Unemployment Compensation Program, Temporary Disability Insurance and new hire files. It should be noted that the State wage information collection agency, the Department of Employment Security, will be implementing SWICA in October, 1988. When SWICA is in place and accessible, the Department of Human Services plans to conduct data exchanges with the SWICA agency.

Relative to the data exchanges with the State Title IVA agency, it should be noted that the Department of Human Services is also the State Title IVA agency and therefore obtains information relative to employed recipients on an on-going basis.

The Workers' Compensation Agency forwards a listing of claims filed with that agency on a monthly basis. These claims are matched against the Department of Human Services eligibility files. Additionally, the Registry of Motor Vehicles will conduct a data exchange with the Department of Human Services eligibility files for the purpose of identifying anyone injured in a motor vehicle accident as a pedestrian, driver, passenger or bicyclist on a semi-annual basis.

Although the Department of Human Services does not utilize ICDCM 9 Diagnostic codes, all claims for payment involving trauma, accident and poisoning are coded with a unique code which encompasses all ICDCM 9 codes 800 thru 999. On a daily basis prior to processing these claims for payment, they are referred to the appropriate specialist to determine the possibility of a third party resource.

Third party liability information obtained from Title IVA applicants and recipients is forwarded on a daily basis to the Division of Medical Services via the AP23 and is posted to the recipient eligibility file.

Third party liability information obtained from applicants and Medically Needy Only recipients; Aged, Blind and Disabled nursing home recipients (non-SSI); Foster Children; categorically eligible medical only recipients; and Three Month Retroactive Eligibility recipients is forwarded to the Division of Medical Services utilizing the AP 757 form which authorizes eligibility and includes third party liability information. Please see Attachment A. The third party liability information is posted to the recipients eligibility file.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island

OFFICIAL

Requirements for Third Party Liability - Identifying Liable Resources

Third party liability information relative to SSI applicants and recipients is forwarded to the Division of Medical Services by the Social Security Administration on an SSA 8019 form in accordance with the provision of the Section 1634 Agreement. This information is posted to the recipient eligibility file.

As Rhode Island is an automatic accretion state, the Social Security Administration accretes all eligible SSI recipients to the SMI Buy-In. This information is posted to the recipient eligibility file on a monthly basis.

Additionally, annual data exchanges are conducted with DEERS and Blue Cross/ Blue Shield of Rhode Island, a major health insurer covering over 80% of Rhode Island's population, for the purposes of identifying, accessing or recouping from the identified third party liability resource.

FOLLOW UP METHODOLOGY

The Department of Human Services utilizes the following methods of follow up for the purpose of identifying and accessing third party liabilities.

Information obtained from the Social Security Administration Wage and Earning File is forwarded to the appropriate eligibility supervisor in the district offices who assign a worker to verify the information. If earning information is already part of the case record, no further action is taken. If wages were previously unreported, the information is verified and referred to the recipient fraud unit if necessary. If the previously unreported employment provides for third party health insurance, it is reported to the Division of Medical Services on an AP23 form which specifies the type of coverage to include the health insurance membership number and the effective dates of coverage. Please see Attachment B. Upon receipt of the AP23 the information is posted to the recipient eligibility file on a daily basis.

Those Workers' Compensation cases involving Medical Assistance applicants and recipients are identified via the data exchange which is conducted monthly. This information is then forwarded to the applicant's or recipient's case worker who has the 175B form which contains specific third party liability information completed by the applicant or recipient. Please see Attachment C. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to insure recovery of the third party resource.

Those motor vehicle accidents involving Medical Assistance applicants and recipients are identified via the semi-annual data exchange with the Registry of Motor Vehicles. Any matches for which the agency has no information is referred

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island

OFFICIAL

Requirements for Third Party Liability - Identifying Liable Resources

to the applicant's or recipient's case worker who has the 175B form completed by the applicant or recipient. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to ensure recovery of the third party resource.

All claims for payment for medical services other than hospital services with a trauma, poisoning or accident related diagnosis are screened by the appropriate specialist for the possibility of a third party liability. Those claims identified for which there is a possible third party resource are returned to the provider and are referred to the Collection and Recovery Unit. The Collection and Recovery Unit sends the information to the recipient's case worker who has the 175B form completed by the recipient. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to ensure recovery of the third party resource.

Additionally, all hospital claims submitted with a trauma, accident or poisoning diagnosis requires the submittal of a TPL1 form. Please see Attachment D. This form gathers information relative to the circumstances surrounding the reason for seeking medical services and inquires as to whether the client is contemplating legal action and identifies the attorney if appropriate. The TPL1 form is reviewed by the appropriate specialist and is forwarded to the Collection and Recovery Unit. The Collection and Recovery Unit sends the information to the recipient's case worker who has the 175B form completed by the recipient. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to ensure recovery of the third party resource.

SUPPLEMENT TO ATTACHMENT 4.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Rhode Island

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

Attachment A

AP-23
4/74

RHODE ISLAND DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES

PERSONAL RESOURCE FOR MEDICAL CARE

OFFICIAL

I. IDENTIFYING INFORMATION

CASE NAME _____ AFDC ☐ MA ☐ _____ (Case #) DATE _____

ADDRESS _____ S.S. # __ __ __/__ __/__ __ __ __

CITY/TOWN _____ TEL. NO. _____

II. MEDICAL INSURANCE PLANS

TYPE OF COVERAGE	Health Insurance Membership Number	Eff. Date of Coverage (If Known)	Resource No Longer Available (Eff. Date)
BLUE CROSS ☐ Individual ☐ Family ☐ Semi-Private ☐ $20.-A-Day ☐ *Co-pay ☐			
BLUE SHIELD ☐ Individual ☐ Family ☐ Plan A ☐ Plan B ☐ Plan U ☐			
MAJOR MEDICAL ☐ Individual ☐ Family ☐			
I. GROUP HEALTH ☐ Individual ☐ Family ☐			
GROUP PLAN UNDER PROV. HEALTH CENTER, INC. ☐ Individual ☐ Family ☐			
FEDERAL MEDICARE ☐ Part A ☐ Part B ☐			
OTHER - Specify			

*Co-pay: Semi-private coverage with insuree responsible for $15.00 per day.

III. MEDICAL NEEDS MET BY OTHER PERSON(S)

PERSON PROVIDING THE SERVICE	SERVICES PROVIDED	Resource No Longer Available (Eff. Date)
(Name) (Address)	HOSPITAL	
(Name) (Address)	PHYSICIAN	
(Name) (Address)	DRUGS	
(Name) (Address)	DENTIST	
(Name) (Address)	OTHER	

Yellow - Medical Standard & Review
White - Record
Blue - Recipient

Signature of Case Aide

RHODE ISLAND DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES

R. O. LOCATION _____ **AUTHORIZATION FOR MEDICAL ASSISTANCE** Attachment B

Initial Certification ☐
Cert. (previously closed) ☐
(previously denied) ☐
[illegible] ☐
[illegible]ification ☐

DATE _____

CASE NUMBER:
MA _____

A. PERSONAL INFORMATION

1. Name: Last First Middle Initial

2. Mail To: Number Street or Avenue

3. City/Town State Zip Code

Former Name of Address, if Changed:

4. Date of Birth

5. Social Security Claim or Account Number

6. Date Eligibility Begins

7. Date Eligibility Expires

8. Prior Category Numbers

9. Cross Reference Number (s)

10. Sex: (Circle One)
1. Male 2. Female

11. (Office Use Only)

12. Marital Status (Circle One)
1. Never Married, 2. Widowed, 3. Married, living with spouse, 4. Divorced, 5. Separated 6. Not Applicable (child)

13. Eligibility Factor (Circle One)
1. 65 & Over 2. Blind 3. Disabled 4. Death 5. Incapacity 6. Absence 7. Unemployed

[illegible]otal Number of Eligible Persons

[illegible] Total Number of Eligible Children

16. Health Insurance (Circle One in a to d below)
a. Social Security Part B. 1. Yes 2. No
b. Blue Cross 1. Yes 2. No. # _____
c. Physicians Service 1. Yes 2. No # _____
d. Other: 1. Yes 2. No If yes, complete:
Name of Company Policy Number

B. ASSETS

1. Does applicant own his own home? (Circle One) 1. Yes 2. No.
2. a. Real Estate $ _____
b. Cash $ _____
c. Stocks & Bonds $ _____
d. TOTAL $ _____
3. Life Insurance $ _____
[illegible]ngible Personal Property $ _____

C. ANNUAL INCOME

1. Net Earned Income $ _____ 2. Social Security Benefits $ _____
3. Other Government Benefits $ _____ 4. All Other Income $ _____
5. Total Income $ _____

D. FLEXIBLE TEST (Circle One)

YES (Code 5) NO (Code 6)

If Yes, show use of $ _____ excess income below:

OFFICIAL

E. FOR FAMILY CASES ONLY

NAME AND BIRTHDATE:

Spouse: _____
Children: _____

CHANGES	NAME	BIRTHDATE
Parent Added		
Parent Removed		
Child Added		
Child Removed		
Previous Unborn		

F. ☐ ELIGIBLE

- The above - named are certified as eligible to receive Medical Assistance benefits.

G. ☐ INELIGIBLE - (Circle one)

1. Closing: Eff. Date _____
2. Rejection

REASON: (Circle One)
1. Does not have category characteristics.
2. Assets are in excess of maximum.
3. Income is in excess of maximum.
4. Eligible for money payment.
5. Death: Date _____
6. Form not returned
7. Other: (Specify) _____

SIGNATURE _____
EIN _____ TITLE _____

MASTER FILE	KEY PUNCH	VERIFY

ATTACHMENT C

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
DIVISION OF ECONOMIC AND SOCIAL SERVICES

AP-175b
Rev. 3/87

ASSIGNMENT OF COLLATERIAL ASSISTANCE

Case Name _____ Case Number _____

Workers' Compensation Yes ☐ No ☐

OFFICIAL

KNOW ALL MEN BY THESE PRESENTS:

WHEREAS: I, _____ SSN _____

on behalf of _____ SSN _____
(injured party)

in consideration of medical care services and support to be furnished to me by the Department of Human Sevices under the provisions of 40-6-7, 40-6-8 and/or 40-8-4 of the General Laws of Rhode Island which assistance of medical care is necessary by reason of accident, injury, or illness sustained on _____ for which the following named third party may be liable:
(date)

Name _____

Address _____

and for which said accident, injury, or illness there are monies expected to be paid and provided to me by said _____, or on his/her behalf by:
(third party)

Insurance Company _____

Address _____

NOW THEREFORE, I, _____, do hereby assign as required by the above-named statutes or programs to the Department of Human Services an amount of money equal to the amount of medical care services and support furnished to me under the aforementioned categories of assistance as a reusult of said accident, injury, or illness.

This assignment and agreement shall not operate as a lien against any amounts due me which are in excess of monies paid by the department for which medical care services and support were given.

I acknowledge that I have read this agreement or that it has been read to me, and I thoroughly understand its meaning before affixing my signature, that the statements herein made by me are true to the best of my knowledge and belief and are made under the penalties of perjury.

WITNESS MY SIGNATURE THIS _____ day of _____, 198____.

*Signature _____

Address _____

Notary or Witness Signature _____

If Attorney, Name _____

Address _____

Agency Representive _____

Office Location _____

***Requires original signature on all six (6) copies.**

ATTACHMENT D

OFFICIAL

Patient: _____
Parent or Guardian: _____
Address: _____
Medical Assistance Number: _____

Where Treated:
Inpatient: _____
Outpatient: _____
Date: _____

In view of the above treatment which appears to have resulted from a condition caused by an injury, the Rhode Island Medical Assistance Program requires submission of the information below before any payment can be made by the State of Rhode Island.

WAS HOSPITAL TREATMENT CAUSED BY AN ON-THE-JOB INJURY? Yes___ No___
If yes, where is patient employed? _____

1. If not injured on the job, where did the injury occur?
   ☐ Home ☐ Highway ☐ Other _____
   Date: _____ Describe what happened: _____

   Do you have any insurance to cover this injury? Yes____ No____

2. Was another party responsible for the injury? Yes____ No____
   If yes, complete remainder of form.

   a. Other Party

      Name _____
      Address _____

      Other Party's Insurance Co.

      Name _____
      Address _____

   b. Do you intend to make a claim against the other party or his insurance company for damages arising from the injury?
      Yes_____ No_____

   c. Have you retained an attorney for the enforcement of your rights? Yes_____ No_____

      If yes, please list his name and address below:
      Name _____ Address _____

   If you answered no to either b or c above and later file a claim, you are required to notify the Medical Assistance Program.

I agree to assign any rights I now have or may have to collateral benefits received as a result of accident, injury, or illness, equal to the amount of medical care or assistance furnished to me.

Signed: _____ Date: _____
Patient or Guardian

TPL-1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island

OFFICIAL

Requirements for Third Party Liability - Payment of Claims

The Rhode Island Medical Assistance Program seeks reimbursement in all instances regardless of the amount involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Rhode Island

Citation	Condition or Requirement
Section 1906 of the Act	State Method on Cost-Effectiveness of Employer-based Group Health Plans
Mandatory Premium Assistance Program	

The following methodology is used to determine the cost effectiveness of an employer-based group health plan for individuals and families subject to enrollment in Medicaid Managed Care.

Introduction

RIte Share is the State's premium assistance program established under the authority of Section 1906 of the Act. Beneficiaries subject to RIte Share include: children, families, parents and caretakers eligible for Medicaid, or the Children's Health Insurance Program (CHIP) covered under the CHIP State Plan, and childless adults between the ages of nineteen (19) and sixty-four (64) who are not receiving or eligible to receive Medicare. All beneficiaries eligible for RIte Share must be enrolled, or be eligible for enrollment, in one of the State's Medicaid Managed Care delivery systems. The state provides a subsidy payment for qualified health insurance plans offered by employers. A qualified plan must meet minimum benefit requirements and maximum cost sharing requirements (deductibles, co-payments and coinsurance), and be determined cost effective.

The subsidy payment is equal to the employee's share of the monthly premium and is generally paid directly to the member. EOHHS ensures that individuals enrolled in RIte Share have access to all Medicaid covered services by directly paying Medicaid enrolled providers for services and cost sharing requirements (generally up to the Medicaid allowable amount) not covered in the commercial plans, as well as services that exceed the coverage limitations of commercial plans.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Rhode Island

Citation	Condition or Requirement
Section 1906 of the Act	State Method on Cost-Effectiveness of Employer-based Group Health Plans

Cost Effectiveness – Concept

On average, the total cost for providing Medicaid covered services through RIte Share must be less than the cost of providing such services through Medicaid Managed Care.

Cost effectiveness is determined in the aggregate by Medicaid Managed Care plan type (i.e., individual, individual pregnant woman, child only, or family). This reduces the administrative burden for the applicant, the employer, and the state. This method is effective in ensuring that the cost to EOHHS for those enrolled in the premium assistance program is less than enrolling those same individuals or families in Medicaid Managed Care.

In order for the state to determine that an employer plan is cost effective, the employee's monthly premium share plus any Medicaid covered services not covered in the commercial plan (all cost sharing wrap and benefits/services covered under Medicaid Managed Care) plus administrative costs, must be less than the average capitation payment (based on age, sex, and average family size) for a Medicaid Managed Care individual. There are (4) four coverage types and income thresholds that the state utilizes to evaluate cost effectiveness for an employer plan:

1. Family coverage where all family members are Medicaid eligible (income less than or equal to one hundred thirty six percent (136%) of the federal poverty guidelines (FPL)- where entire family is Medicaid eligible);
2. Family coverage where children in the family are Medicaid eligible (income greater than one hundred and thirty-six percent (136% FPL), and less than or equal to two hundred and sixty one percent (261% FPL) for families with children provided cost effective to also pay for parents;

3. Family coverage where pregnant women are eligible, i.e., income greater than one hundred and thirty-six percent (136%), and less than or equal to two hundred fifty three percent (253%) of FPL);

Citation	Condition or Requirement
Section 1906 of the Act	State Method on Cost-Effectiveness of Employer-based Group Health Plans

4. Individual coverage where only the employee is Medicaid eligible (133% FPL) (Medicaid Expansion).

All the above listed FPL guidelines are not inclusive of the five percent (5%) income disregard.

Methodology

The state uses a calculator to determine cost effectiveness for each type of coverage. The calculator takes into account the actuarial values of all applicable premiums, cost sharing wrap (including deductibles and coinsurances amounts), benefits wrap (based on ESI benefits maximums and Medicaid Managed Care only benefits) and RIte Share administrative costs, compared to an Employer Sponsored Insurance (ESI) plan when determining cost effectiveness.

The process for determining cost effectiveness is outlined below:

1. Prospectively determine the average value (cost) of Medicaid Managed Care capitation for the time period and population under consideration;
2. Identify and determine the average actuarial value(s) of the cost sharing and benefit differences between Medicaid Managed Care and RIte Share approved employer sponsored insurance (ESI) plans– including differences in copays, deductibles, coinsurances amounts, benefit maximums and Medicaid Managed Care only benefits to determine the benefits to be wrapped.
3. Determine and allocate net operational costs to administer RIte Share.
4. Calculate the subsidy threshold, as the average Medicaid Managed Care value minus the actuarial value of the benefit difference determined in step 2 and the net operational costs determined above in step 3.

RIte Share ensures that members do not need to pay out of pocket costs that exceed nominal cost sharing in the following ways:

Citation	Condition or Requirement
Section 1906 of the Act	State Method on Cost-Effectiveness of Employer-based Group Health Plans

1. If a member obtains care from a provider that is both a Medicaid participating provider and participating in the ESI network, Medicaid pays secondarily to the ESI plan up to the Medicaid negotiated rate
2. If a member intends to obtain care from an ESI provider that is not participating with Medicaid, members are instructed to:
    a. Contact EOHHS so that EOHHS may negotiate with such provider to cover cost sharing wrap.
    b. If the state cannot reach agreement with such provider through the fee-for-service network, the state will review the case to determine if the member meets "good cause" for disenrolling from the ESI plan in order to maintain continuity or access to care and ensure that the beneficiary does not incur out-of-pocket costs for cost sharing. The state ensures continuity of care for these individuals when disenrolled from RIteshare by enrolling them with a Medicaid Managed Care Organization (MCO) that may be able to contract with the provider at issue. Reasons for "good cause" may include, but are not limited to the following:
        i. the member is being treated for a condition by this provider,
        ii. there is a long-standing provider/beneficiary relationship
        iii. the member cannot access medically necessary care.
    c. In the case that good cause is determined, the member will be notified and enrolled in the MCO in which the provider in question participates. In the case that none of the Medicaid MCOs contract with the provider in question, the member may choose an MCO, and the MCO may work to contract with the provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Rhode Island

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

There is a written agreement between the Rhode Island Department of Human Services (DHS) and the Rhode Island Department of Employment Security (DES) to exchange information for purposes of establishing an income and eligibility verification system in accordance with the provisions of Section 2651 of the Deficit Reduction Act of 1984 (DEFRA) which amended Title XI of the Social Security Act and Section 303 of Title III of the Social Security Act. Further requirements for the system were published as Secretary of Health and Human Services and Secretary of Labor final regulations in the FEDERAL REGISTER February 28, 1986, at 42 CFR 431, 435 and 20 CFR 603. In accordance with the above law and regulations and Chapter 28-42 of the Rhode Island Employment Security Act, DHS and DES agree as follows:

DHS Actions

DHS will prepare a computer tape record, following Standardized Format Type I, as defined in the Standardized Formats Guidelines and Procedures developed by the Department of Health and Human Services, to be submitted to the DES on or about the 15th and 30th of each month, requesting current unemployment insurance benefit data as required in Standardized Format Type 3.

DES Actions

DES will prepare an initial output tape (which will consist of Standardized Format Type 3 following the instructions and guidelines in the Standardized Formats and Procedures) within 10 weeks of receipt of the initial computer tape. Subsequent output tapes will be prepared within 5 working days of receipt of each computer tape.

Matters of employee bonding, confidentiality, administrative costs, and nondiscrimination requirements are addressed within the agreement.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: RHODE ISLAND
INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
TARGETING METHODOLOGY

STATE FOLLOW-UP PLAN FOR INFORMATION ITEMS RECEIVED FROM MATCHING OPERATION UNDER THE INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS).
The categories of IEVS information items excluded from follow-up and the State's justification for excluding such categories from follow-up are defined below. Medical Assistance cases which fall below the identified tolerance levels are excluded from follow-up.

A. SOCIAL SECURITY BENEFITS MATCH:

I. Community Cases

a. $50.00 annual tolerance for discrepancy between amount on the DHS file and an adjusted yearly Bendex file for all community-based cases with the exception of Flexible Test of Income cases. $1.00 annual tolerance for Flexible Test of Income cases which have achieved Medical Assistance eligibility as a result of meeting a spend-down liability.

b. Experience has demonstrated that a lower tolerance would generate a large number of matches with follow-up resulting in a small percentage of cases whose eligibility would be affected.

II. Long Term Care Cases

a. $1.00 annual tolerance for discrepancy between amount on the DHS file and an adjusted yearly Bendex file for all Nursing Facility, Intermediate Care Facility-Mental Retardation, and Home & Community Based Services Waiver cases.

b. Tolerance allowed as rounding techniques used by the different programs cause insignificant variations. The tolerance is set low as income is used to determine the liability applied to cost of care.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: RHODE ISLAND
INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
TARGETING METHODOLOGY

B. SOCIAL SECURITY WAGE MATCH:

I. Community Cases

a. $1360 per year per employee which represents eight weeks of employment at the minimum wage. (Currently $4.25 x 40 hrs. x 8 wks.)

b. Tolerance originally set at $150 per employee per year. Calendar year 1989 match resulted in 722 hits with only 11 closures and demonstrated that this tolerance is not cost effective. Tolerance is now to be tested as described above since individuals employed less than 8 weeks/year were only loosely connected with the work force and not likely to be currently employed or to have past or present earnings in excess of the MNIL. Also, this tolerance is comparable to that employed by other states in the region. Additionally, Rhode Island will be identifying current earners through SWICA.

II. Long Term Care Match

a. No follow-up on match conducted.

b. Experience has demonstrated that the likelihood of individuals in nursing facilities being employed would not justify the expense of processing a match. Administrators of mental retardation facilities submit monthly earned income reports on employed MR individuals as a quality control corrective action.

C. UNEMPLOYMENT COMPENSATION BENEFIT MATCH:

I. Community Cases

a. Tolerance is $0.00.
b. Matched dollar for dollar.

II. Long Term Care Cases

a. Tolerance is $0.00.
b. Matched dollar for dollar.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: RHODE ISLAND
INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
TARGETING METHODOLOGY

D. INTERNAL REVENUE SERVICE UNEARNED INCOME MATCH:

I. Community Care Cases

a. $200.00 annual tolerance for Medically Needy.
$100.00 annual tolerance for Categorically Needy for Aged, Blind, or Disabled characteristics.
$50.00 annual tolerance for Categorically Needy Foster Care and AFDC characteristics.

b. The basic asset limit for Medically Needy individuals and families is $4,000. The basic asset limit for Categorically Needy individuals is $2,000 and for Categorically Needy families is $1,000. Based on a plausible 6% interest rate, the tolerances would target those with interest-generating resources exceeding $3300, $1650, and $825 respectively while allowing a reasonable buffer. The potential for additional unreported resources exceeding the limits if taken in aggregate exists. However, that potential remains regardless of the amount of tolerance if the additional assets are not of an interest-generating nature. Experience has demonstrated that interest earnings of less than the tolerances indicate resources within the program asset limits.

II. Long Term Care Cases

a. $200.00 annual tolerance for Medically Needy.
$100.00 annual tolerance for Categorically Needy for Aged, Blind, or Disabled characteristics.

b. Same justification as in D.,I., b. above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

OFFICIAL

Medical Assistance Eligibility Cards are made available to eligible homeless individuals and families at the district office which received the application, or are mailed to a mailing address provided by the recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: RHODE ISLAND

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

The only Rhode Island laws governing the area of advance directives are Title 23, Chapter 4.10 entitled *Health Care Power of Attorney*, and Title 23, Chapter 4.11 entitled *Rights of the Terminally Ill Act*. Chapter 4.10 concerns the use of a statutory form of durable power of attorney and Chapter 4.11 establishes a procedure whereby terminally ill persons could have life-sustaining procedures withheld or withdrawn. This description is provided in summary of and not in substitution for a careful reading of the statutory provisions cited herein.

Statutory Form Durable Power of Attorney for Health Care

The Statutory Form Durable Power of Attorney for Health Care gives the agent full power and authority, except to the extent that there are limits provided by law, to make health care decisions consistent with the desires of the individual executing the document. The power is subject to any statement of desires and any limitation included in the document by the principal.

The person executing the durable power of attorney for health care must be at least eighteen (18) years of age and a resident of the state of Rhode Island. Notwithstanding the document, the principal retains the right to make medical and other health care decisions as long as informed consent can be given with respect to the particular decision and no treatment may be given or health care stopped or withheld over the objection by the principal at the time.

For purposes of the document "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

A court can take away the power of the agent to make health care decisions if the agent (1) authorizes anything that is illegal, (2) acts contrary to the known desires of the principal, or (3) where the desires of the principal are unknown, does anything that is clearly contrary to the best interests of the principal.

Unless specified for a specific period the durable power of attorney for health care exists until revoked by the principal and the agent's power and authority cease upon death of the principal. The principal may revoke the authority of the agent by notifying the agent or the treating doctor, hospital, or other health care provider orally or in writing of the revocation.

The agent has the right to examine and consent to the disclosure of medical records unless the right is limited by the document.

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REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The document must be witnessed by two (2) qualified witnesses who are present when the principal signs or acknowledges signing the document. Any additional pages attached to the form must be individually signed and dated at the same time the principal dates and signs the durable power of attorney. None of the following may be used as a witness: (1) the person designated by the principal as the agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility.

A declaration, under penalty of perjury, must be made by one or the other of the witnesses that the principal is known to the witness; that the principal signed or acknowledged the durable power of attorney in the presence of the witness and appeared of sound mind and under no duress; that the witness is not the person appointed as attorney in fact; that the witness is not one of the above identified as ineligible to be a witness. An additional declaration, under penalty of perjury, must be made by one or the other of the witnesses that the witness is not related to the principal by blood, marriage, adoption, and, to the best of the witness's knowledge, the witness is not entitled to any part of the estate of the principal under an existing will or by operation of law.

Rights of the Terminally Ill Act

This Act recognizes the right of an adult person to make a written declaration instructing his/her physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition and establishes a procedure whereby terminally ill persons can have life-sustaining procedures withheld or withdrawn.

A competent individual eighteen (18) years of age or older may at any time execute a declaration governing the withholding or withdrawal of life-sustaining procedures. The declaration must be signed by the declarant, or another at the declarant's direction in the presence of two (2) subscribing witnesses who are not related to the declarant by blood or marriage. A declaration has operative effect only when (1) the declaration is communicated to the attending physician, and (2) the declarant is determined by the attending physician to be in a terminal condition, and (3) the declarant is unable to made treatment decisions.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

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JUNE 1995

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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CRITERIA FOR THE APPLICATION OF SPECIFIED REMEDIES FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES
(When and how each remedy is applied, the amounts of any fines, and the severity of the remedies)

1. The Rhode Island Department of Human Services, pursuant to departmental regulations, provides no Medical Assistance payment for patients admitted to a nursing facility subsequent to a finding by the Rhode Island Department of Health that the facility does not comply with the requirements of Sections 1919 (b), (c), and (d).

2. The Rhode Island Department of Health is directed by R.I.G.L. 23-17-10.3 et seq. to assess and collect with interest an administrative penalty. Such administrative penalty relates to severity of the compliance failure, the resultant actual or potential damage, whether previous penalties have been assessed, and other factors. Each occurrence of a violation and/or day a violation exists constitutes a separate and distinct violation for purposes of penalty assessment.

3. The Rhode Island Department of Health is directed by R.I.G.L. 23-17-10.6 et seq. to petition Superior Court to appoint a receiver to protect the health,safety, and well being of the facility's residents when the Department of Health determines that the facility is being managed in a manner detrimental to the health, safety, and well being of the residents of the facility. Such receiver has the statutory authority to operate the facility while improvements are made to bring the facility into compliance.

4. The Rhode Island Department of Health is directed by R.I.G.L. 23-17-10.6 et seq. to petition Superior Court to appoint a receiver to protect the health, safety, and well being of the facility's residents when the Department of Health determines that the facility is being managed in a manner detrimental to the health, safety, and well being of the residents of the facility. Such receiver has the statutory authority to close the facility and effectuate the safe and orderly removal and placement of its patients.

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DEFINITION OF SPECIALIZED SERVICES

SPECIALIZED SERVICES

Mental Illness

Specialized services do not have to be provided by nursing facilities. The term "Specialized Services" is equated with the level of care provided in psychiatric hospitals, or other intensive programs staffed with trained mental health professionals on a 24-hour/day basis. The patient's care follows the aggressive implementation of a treatment plan developed by an interdisciplinary team including a physician and other qualified mental health professionals and incorporates therapies supervised by these professionals. Treatment is aimed at diagnosing and reducing behavioral symptoms to improve the patient's level of functioning to a point that permits a reduction in intensity of services as soon as possible. While some of these services may be the same as those required to be provided by the nursing facility, it is their intensive level that sets them apart.

Mental Retardation

A continuous program for each client, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward: 1) the acquisition of the behaviors necessary for the person to function with as much self determination and independence as possible; and, 2) the prevention or deceleration of regression or loss of current optimal functional status. Specialized Services does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous specialized services program.

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CATEGORICAL DETERMINATIONS

The State Medicaid authority may make an advance group determination in conditions where:

1. Care of a terminal illness with a life expectancy of less than six months and requires NF care.

2. Care of a severe illness which results in a level of impairment so severe that this individual could not be expected to benefit from specialized services. "Severe illness" includes but is not limited to, comatose, ventilator dependent, functioning at the brain stem level, chronic obstructive pulmonary disease, Huntington's disease, Parkinson's disease, amyotrophic lateral sclerosis and congestive heart failure.

3. Provisional admissions with documentation of recommended NF medical and psychiatric follow-up; pending further assessment in case of delirium where an accurate diagnosis cannot be made until delirium clears, no more than 30 days after NF admission.

4. Provisional admissions pending further assessment in emergency circumstances requiring protective services to assist in removing an individual from a situation in which s/he is being abused, neglected, and/or exploited. Placement in a NF is not to exceed 7 days.

5. Very brief and finite stays of up to 30 days to provide respite to in-home caregivers to whom the individual with MI or MR is expected to return following the brief NF stay.

*U.S. G.P.O.: 1993-342-239:80013

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF RHODE ISLAND

Rhode Island will re-assess an entity's compliance to Section 1902 (a)(68) of the Social Security Act by having entities certify at the time of enrollment and at re-enrollment, and no later than every two years, that they are in conformance with Section 1902 (a) (68) of the Act. Entities will be notified on bi-annual basis and within the first month of the quarter of reenrollment that they will need to submit a certification document that will be filed with the entity's enrollment information.

The State will identify entities that receive or make annual Medicaid payments of at least $5 million in expenditures in calendar 2006 and will require them to sign a Certification of Compliance Form for 2007. The State will notify entities by August 31, 2007 and certifications must be received by DHS within 45 days of notification.

The State will use a self-declaration method to ensure compliance to the Act by requiring providers to sign a Certification of Compliance Form. The state will conduct on an annual basis a desk audit of at least 2% of the entities to ensure compliance to the act. The state will review the actual policies, procedures and employee handbooks during the desk audits.