Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd floor, Cranston, RI 02920
phone: 401.462.2132 fax: 401.462.0458

May 13, 2015

Docket # 14-1593
Hearing Date: October 9, 2014
Reconvene Date: March 26, 2015

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided in your favor with regards to **some** of your medical expenses. During the course of the proceeding, the following issue(s) and Agency regulation(s) were the matters before the hearing:

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)

SECTION 1310: Rhody Health Partners For MACC Group Adults-19 to 64
SECTION 1311: Enrollment Process: Rite Care and Rhody Health Partners Managed Care Plans

The facts of your case, the Agency regulations, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: You (the appellant), Agency representatives: Cheryl Tremblay, Jack Demus, Marlanea Peabody, Robin Etchingham, Maria Volpe, and United Healthcare Compliance officer, Maria L. Viveiros.

Present at the hearings were: You, your mother, Agency representatives: Cheryl Tremblay and Jack Demus, and United Healthcare representative, Maria Viveiros.

ISSUE: Should the appellant have some/or all of his medical expenses incurred between May 1, 2014 and July 1, 2014 covered by his carrier-United Health Insurance?

EOHHS RULES AND REGULATIONS;
Please see attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services Medicaid Code of Administrative Rules (MCAR).

DISCUSSION OF THE EVIDENCE:

The DHS Agency representative testified:

- Based on the Health Source RI (HSRI) notice dated May 30, 2014, the appellant became eligible for Medicaid beginning on May 1st.
- The notice that he received indicated he was eligible for Medicaid coverage through HSRI as of May 1, 2014, and it explained how to access Medicaid fee-for –services not covered by his Medicaid health plan by using his White Medicaid Anchor Card, or presenting the notice to the provider.
- The Anchor card is the Medicaid card.
- The notice further states that he had selected United Healthcare, and "If you are eligible to enroll with this health plan, you will receive a separate letter from United Healthcare with your member ID card and information about how to use coverage."
- The notice never states that the United Healthcare has started, it clearly states the Medicaid started on May 1, 2014.
- The notice does not indicate that there are two different starting dates-one for Medicaid, and one for United Healthcare.
- There were no other generated notices which indicated when his United Healthcare coverage would become active.
- The Agency had not received any phone calls from the appellant about coverage starting dates.
- The four July notices do not indicate different starting dates of eligibility for the two coverages. There were no other notices since July.
- This morning (Oct.9th), this worker contacted the DHS representative who is responsible for enrollment statuses for HMO's, and he identified that the coverage began on July 1, 2014.

The OHHS Agency representative testified:

- Our records show that the appellant was enrolled in the Medicaid expansion health program effective July 1, 2014.

- Our records also show that the policy information was added into the Medicaid system on June 2nd for a prospective enrollment date of July 1, 2014.

- This is a common procedure to enroll prospectively so that there is notice given to the health plan and payment is sent to the health plan.

- OHHS contracts with United to provide medical health care services.

- Enrollment is prospective enrollment which takes place monthly for adults, and it depends on the date the eligibility is approved.

- So, if the notice was issued on May 30th, Medicaid eligibility would go back to the first of the month of application-May 1st; but, the enrollment would be prospective usually 30-45 days.

- In this case the policy was added on June 2nd for a prospective enrollment on July 1st, which is how the system works.

- You (the appellant) needed to have a discussion with your providers when you went into their offices prior to having any coverage.

The United Healthcare representative testified:

- Per the state eligibility site, the member's coverage did not become effective with United until July 1, 2014.

- It shows that they have Medicaid coverage effective 5.1.14.

- United was not informed by EOHHS of the member's enrollment until June 11, 2014 for a July 1st begin date. That is when we received an eligibility file.

- On June 13, 2014 we mailed out the member's ID card which specifies the coverage begins on May 1, 2014.

- For ACA expansion, the coverage always starts at the beginning of the month.

- The representative listened to the recording. The reference number given was not an authorization number but a number which links the call to allow looking up the call if needed.

- The call did not establish eligibility, and at no time did the representative (United) give a starting date of May 1, 2014.

- That information could not be verified based upon the phone call.

- Additionally, United has not received any claims from the physical therapist for the dates in question.

- The first claim was for a date of service of July 2, 2014, and the second was for July 9th service, indicating that the provider did not think they should be billing United Health prior to that date.

- If the provider had gone into the Provider portal where they are able to look up eligibility it would have indicated that the member's eligibility did not begin until June 1, 2014. The appellant cannot access this portal.

- Also, on the day the therapist called that is the same day we received the member's eligibility so we would not have had the member's eligibility in our system to allow the representative to look him up and verify that the member had eligibility as of May 1, 2014.

- We dispute the information given by the physical therapist.

- The other bills he (the appellant) is disputing should not be covered by United.

- If Medicaid did not cover one of the prescriptions it is doubtful that United would cover as they have the same formulary.

The appellant and his mother testified:

- He (the appellant) sustained a back injury on May 20, 2014.

- He went to the doctor on May 29, 2014, and the doctor told him to get physical therapy and to call Health Source RI (HSRI).

- On May 29th, he contacted HSRI by phone, and signed up for coverage through HSRI.

- During that initial call, the family chose UnitedHealth, and the HSRI representative told the appellant and his mother that he was covered right then and there as well as retroactively to May 1st.

- The appellant did receive the May 30, 2014 notice although it has his mother's name incorrectly on the initial paperwork.

- He contacted LePre (Physical Therapy facility) because he needed physical therapy (PT) following his accident.

- LePre told him they did not accept Anchor (Medicaid card), but did accept UnitedHealth.

- The appellant showed LePre the "dashboard readout" from Health Source RI (HSRI), as that was all that they were able to obtain on line at the time. They printed it out and brought that to LePre.

- The read out showed eligibility for Medicaid coverage, and indicated "You will receive a separate letter from United Healthcare Community Plan of RI with your member ID card and information about how to use."

- The read out also showed that Medicaid would start on May 1, 2014, and that the appellant had applied on May 29, 2014.

- LePre informed the appellant that they had contacted Adriana of United Healthcare and she said he was covered and could schedule his first appointment. She gave a reference number to LePre and informed them that there would be no copay or deductible needed.

- All this took place prior to starting the therapy.

- Therapy began on June 11, 2014 and ran through July 9, 2014.

- The July 17, 2014 bill from LePre was the first time the appellant knew he had not had coverage.

- The July 17, 2014 bill from LePre showed that therapy began on June 11, 2014, and beginning on July 2nd, there were no further charges.

- The initial balances through July 2nd were later adjusted because LePre informed the appellant they reduced the amount as the appellant did not have coverage during that period.

- When the appellant found that he was not covered, his mother contacted United Healthcare and asked them to listen to the recording between LePre and their Agency to confirm they had gotten preauthorization-they refused to review it.

- The appellant has other outstanding medical bills from the time of the injury.

- He cannot remember when he got the United Healthcare cards, and they do not show any starting dates on them. The initial mailing envelope shows no dates either.

- The appellant remembers that he brought the card in to one therapy session because the facility noted that the card had the wrong primary doctor's name on it. They sent it back to have it corrected.

- The appellant would like to keep the record open to submit additional evidence.

- There is a $204 therapy bill, and a $75 bill from the May 29th Urgent care visit, May 29th X-rays costing $94.00, several CVS bills, and a doctor's visit for $75.00.

- The original doctor knew we had no coverage, and the X-ray was immediately adjusted because we had no coverage and agreed to pay cash.

- One of the CVS bills was paid, but one of the two prescriptions was not covered by Medicaid after resubmitting.

Summary of the recording between the representatives from LePre Physical Therapy and the United Health care resolution specialist:

- The initial United Health care operator identifies she has a provider on the line with a plan that the operator is unable to service, and wants to be sure the United representative is able to service the plan. The United Resolution Specialist, Adrianna, tells her to put the call through. Adrianna informs the PT representative, that she does have the ID # for that member. The LePre Physical Therapy (PT) representative, Jane verbalizes, "Actually we are looking for PT benefits for"...the member in question. The United representative, Adrianna, discusses the inpatient/outpatient coverage. The PT representative expresses relief when Adrianna tells her the member does not need prior authorization. Jane asks about copay? She is told there is no copay, no deductible; no co-insurance"-it's covered." She then adds, "according to the Medicaid allowable." She asks if she should bill United directly under this ID number. The PT representative adds, "I'm just making sure, because I've been trying to confirm this for a couple of days." LePre representative asks for a reference number. She then asks if there is any other line to call when they want to confirm these types of insurances going forward. The United representative initially identifies, "Yes, there is a different number for Medicaid". She then realizes that the numbers are the same and corrects that information.

FINDINGS OF FACT:

- The appellant received a physical therapy bill dated July 17, 2014 for services received between June 11, 2014 and July 9, 2014.

- The appellant appealed the July 17th bill and filed a timely request, submitted on July 23.

- A hearing was held on October 9, 2014.

- Per the appellant's request, the record of hearing was held open until October 23, 2014 for submission of additional evidence. Additional evidence was received from the appellant.

- Following receipt of additional evidence a reconvene was requested in order to allow the Managed Care Organization to respond to the evidence.

- A reconvene was held on March 26, 2015, and the record was held open until April 9th to obtain a copy of a taped conversation between providers.

- On April 17, 2015, upon receipt of a response from United Health care provider, the appellant requested a held open extension to listen to the tape which she had chosen not to receive prior. The tape was sent to the appellant and the record of hearing was held open until May 1, 2015 for response.

- No further response was received.

- The appellant sustained an injury on May 20, 2014.

- The appellant had no health coverage as of this date.

- The appellant utilized and was billed for services from an Urgent Care center on May 20, 2014.

- The appellant obtained and paid for X-rays on May 29, 2014.

- On May 29th, the appellant attended and was billed for a doctor's appointment.

- On May 29, 2014 the appellant signed up for health insurance by contacting Health Source Rhode Island (HSRI) by phone.

- The appellant obtained a "dashboard" readout from HSRI on May 29, 2014 which indicated Medicaid-fee for service start date May 1, 2014, and "You are eligible for Medicaid coverage..." "You will receive a separate letter from United Healthcare Community Plan of RI with your member ID card and information about how to use your coverage."

- A May 30, 2014 HSRI generated notice informed the appellant he was eligible for Medicaid coverage through HSRI, had selected United Healthcare, and if eligible to enroll with this plan, would receive a separate letter from United Healthcare with a member ID card and information about use of coverage. The notice identified an effective coverage date of May 1, 2014.

- The appellant's information was added into the Medicaid system on June 2, 2014.

- United Health care received the appellant's eligibility file on June 11, 2014.

- The United Health care cards were mailed to the appellant on June 13, 2014. The packet contained notice that the start date for United Health Care was July 1, 2015. The cards themselves contained no start date, and contained incorrect information as to the PCP.

- A letter dated October 17, 2014 was submitted from Lepre Physical Therapy indicating the appellant was first seen at the facility on June 11, 2014, and that prior to the initial appointment the United health care provider was contacted to verify coverage. The letter included the name of the contact person, and the effective date of coverage as May 1, 2014. Additionally, the letter indicates the agency was told there would be "no copay required", and "no deductible applies".

- A Physical Therapy bill dated July 17, 2014 shows charges incurred by the appellant for appointments up until July 1, 2014, the date the United Health coverage began.

CONCLUSION:

The issue to be decided is whether the appellant should have some/or all of his medical expenses incurred between May 1, 2014 and July 1, 2014, covered by his carrier-United Health Insurance?

The Medicaid provisions of the federal Affordable Care Act (ACA) were implemented January 1, 2014, as a means to improve health coverage for people of all ages and income levels. A new coverage group was established for adults between the ages of 19 and 64, whose main characteristics included qualified citizens not otherwise eligible for other forms of Medicaid, and who also met the financial requirements. Rhody Health Partners (RHP) is the managed care delivery system for this group of Medicaid eligible adults. Enrollment in a managed care organization is mandatory for this group.

There is no dispute that the appellant was eligible to be enrolled in this system of care. There is no dispute as well that he enrolled by contacting Health Source Rhode Island (HSRI) by phone on May 29, 2014. According to a May 30, 2014 HSRI notice, the appellant was enrolled in Medicaid coverage retroactively to May 1, 2014.There is no dispute as well, with regards to the Physical therapy (PT) benefits, that the appellant believed that his PT facility contacted and received approval for him to begin services, and that they would be covered. He began physical therapy services on June 11, 2014.

The appellant argues two separate issues. He states that the initial "dashboard" readout from HSRI, and the initial notice from HSRI dated May 30, 2014 were either confusing,

or misleading with regards to the omission of information about two differing coverage starting dates for the Medicaid fee-for–services and the actual enrollment date in a separate Medicaid Health plan-in this case-United Health care. The second issue in contention is the appellant's subsequent receipt of a bill for physical therapy services which he thought were covered by his health provider.

With regards to the first issue-the appellant signed up for health insurance on May 29, 2014 via a telephone call to HSRI. Prior to this, he sustained an injury on May 20, 2014. Evidence submitted at hearing shows that the appellant was seen at a local Urgent Care Center on that same day, and obtained medication as well. At that time, the appellant states that he had no medical coverage. Testimony and evidence submitted indicates that on May 29th, the appellant obtained both an X-ray followed by a doctor's appointment with his primary care doctor. The appellant informed the Radiology facility he did not have medical coverage and he was given a reduced rate for paying cash. The appellant then saw his doctor who advised him to obtain medical coverage immediately by signing up for coverage through HSRI. He also recommended that the appellant arrange for physical therapy services. On May 29th the appellant contacted HSRI and signed up for coverage. He testified that the HSRI representative told him he was covered, but did not tell him there were two differing starting dates. The appellant testifies that he and his mother were able to obtain only the "dashboard" readout from the computer which identified the plan was Medicaid-fee for service, beginning on May 1, 2014. The document further reads that the appellant is eligible for Medicaid coverage. It continues-"thank you for selecting United Healthcare Community (UHC) Plan of RI. You will receive a separate letter from UHC community plan of RI with your member ID card and information about how to use your coverage. The subsequent notice dated May 30, 2014 generated the next day, both on line where the appellant had already obtained his dashboard readout; and, he was sent, and received a hard copy at his home. That notice identified that **if** the enrollee was eligible to enroll with the United Health plan as chosen, he would receive a separate letter from UHC with a member ID card and information about usage. It further directed him to use his White Medicaid Anchor Card or the actual notice for presentation to providers as needed. The notice further recommends a number to contact in the event of questions specific to the notice. The appellant argues that the notice never indicated that start dates for Medicaid fee-for–service, and enrollment in a separate Medicaid managed health plan-United, were two different dates. Neither the original dashboard nor the subsequent notice indicated a start date for the managed care plan. Thus, he assumed the start date of May 1 (retroactive coverage eligibility for Medicaid) applied to his UHC coverage as well. The appellant requested payment for the services and medications received from May 20, 2014 through May 30th resulting from his confusion about the notices themselves. However, the appellant testified that he did not sign up for insurance until completion of the Urgent care visit, an X-ray, two doctor's visits, and medication recommendations. Thus, the issue of the notices was not a consideration when the appellant actually incurred the fees. The appellant identified that he may not have informed the first provider that he did not have medical coverage. He further testified that he did not discuss the possibility of billing with his primary doctor or any other providers prior to his appointments. He did not discuss how or whether any individual providers would accept

the medical coverage he would be attempting to enroll in. The new ACA coverage, often called "Obama care", was a well-publicized medical coverage program which mandated that the appellant have coverage, and which also would have been free of charge for the appellant due to his financial status. Despite this, the appellant did not enroll for the first five months it was offered, and only signed up ten days after he was injured. He did not ascertain if any of his providers prior to his application, would accept or participated in the RI Medicaid program, as he had not yet signed up for any insurance.

Further exploration of regulations indicates that two identification cards-permanent health plan cards and permanent Medicaid cards must be issued within 15 days of enrollment. In this case the appellant was sent his United health cards on June 13, 2014 within policy guidelines, and he was informed per notice that the notice could serve as his Anchor card until received. It is unclear when the appellant received his Anchor card. Policy also determines the use of interim fee-for-service coverage between Medicaid health plan assignment and plan enrollment. It notes that services must be delivered to the Medicaid member by a health provider or practitioner certified to participate in the RI Medicaid program. The DHS representative testified that at no time had the appellant contacted DHS to inquire about what they considered the confusing notice, or what benefits were allowable per the May 30th notice, or what providers were acceptable. The appellant testified he never had any discussions with providers about how the bills would be covered.

The OHHS representative testified that they had entered the policy information into the Medicaid system on June 2, 2014 for a prospective enrollment date of July 1, 2014. He identified that this is common practice so that there is notice given to the health plan and payment is sent to the health plan as well. OHHHS contracts with United to provide medical health services. He identified that enrollment takes place monthly, and it depends on the date the eligibility is approved. Evidence submitted shows that the May 30, 2014 enrollment notice reads, you have selected United Health care, and "**If** you are eligible to enroll with this plan"... The inference is that the appellant is not yet in the UHP program. He further noted that Medicaid eligibility would go back to the first of the month of application, but the enrollment in the health plan would be prospective usually about 30-40 days. The UHC representative agreed that ACA expansion coverage allows for the coverage to start at the beginning of the month. Thus, the coverage would not begin until July 1, 2014. The UHC representative indicated that on June 11, they were informed by EOHHS of the member's enrollment, and were given an eligibility file. On June 13, they mailed out the member's ID card which also included in the information, a starting date of July 1, 2014. The appellant pointed out that the cards did not themselves have a starting date, and that the cards were incorrect as well, as they listed the wrong PCP, and needed to be returned and reissued. He testified to being unaware of the differing start dates. The UHC representative disputes paying any outstanding out of pocket medical costs incurred prior to the effective date of July 1st. She further recommends that all bills be submitted through Medicaid Fee-for–Service, as several of the claims had already been reimbursed in that manner which she testified suggests an awareness by the member that he was not yet in the plan, but under Medicaid-fee-for-service stature.

The second and primary issue for the appellant is that he believed he had obtained prior eligibility authorization for receipt of therapy services through his physical therapy (PT) provider, LePre. He argues that upon receipt of the subsequent PT bill he realized that he was not covered for medical insurance. He testified and submitted into evidence an October 17 letter which verified that LePre had contacted the UHC provider, and had been informed of the following: the therapy agency had called to verify coverage prior to beginning services, the contact person was Adrianna, the date of contact was June 11, 2014, the effective date of coverage was May 1, 2014, there were no copays, and no deductibles applied. A reference was number was given, and the call between providers had been recorded.

The UHC representative disputed some of the information presented by LePre. She disputes that the call establishes eligibility, that no starting date was presented, and that the reference number given was an authorization number which links calls to allow locating those calls at future dates. She further opined that the PT provider could have accessed the online Provider portal to determine eligibility dates herself, and that the United Health Care (UHC) rep. could not have found the member's eligibility in the system to identify the starting date of May 1st as the PT provider called the same day the information was received from EOHHS. Additionally, the UHC representative presented a PT bill which did not include any requests for June physical therapy services. She determined that was a result of the facility being aware that the appellant did not have coverage, and thus did not bill.

Post hearing, a copy of the recording was received. The recording begins with an initial few seconds of discussion between a United Health care operator and the UHC resolution specialist. The operator identifies that she has a provider (LePre) on the line with a plan that the operator is unable to service. She wants to be sure the United resolution specialist is able to service the plan. She is asked to put the call through. The resolution specialist identifies she does have an ID # for the member. The PT representative informs UHC she is looking for PT benefits for this individual. She is told he does not need prior authorization, he does not have copay, he has no co-insurance, and no deductible. She adds, "It's covered." She then adds "according to the Medicaid allowable." The representative expresses relief that she need not get prior authorization. She questions whether she should bill United directly. She informs the resolution specialist she has been trying for days to get confirmation "for these types of insurances." She asks if there is another number for future confirmations. The PT representative restates, "I'm just making sure."

The tape submitted into evidence, supports the UHC representative's testimony that no starting date of eligibility was ever discussed. Additionally, the LePre representative, Jane, never identified directly that she wanted the member to begin immediately. However, the call demonstrates that the PT representative has been waiting to allow this member to start. She states she has been trying for days, suggesting some urgency in beginning. She asks for the ID number, which she is given, and then asks if she should bill UHC directly. She questions billing protocol, deductibles, and co-pays. She is relieved when the operator corrects herself and states, he does not need prior

authorization for services. She responds, "whew". Jane repeats that she is looking for a number to confirm other cases in the future-the inference being that she is confirming this member now. Jane identifies she is looking for PT eligibility. Jane identifies she is "just making sure". Jane contacts the resolution specialist, who is the authority in this matter, to determine "confirmation" and "eligibility".

The Agency contends that the PT provider was aware that the services had not been covered because they did not bill for June services prior to the bill sent out for July coverage. However, the record does not establish the motive behind the billing, and the PT representative was unavailable at hearing and had already sent evidence indicating that she had thought she had gotten authorization through UHC.

In summary, although the appellant considered the initial dashboard and subsequent notices to be confusing, the appellant was not in receipt of that paperwork during any of his initial appointments as they took place prior to his signup for medical coverage. Additionally, the appellant testified to obtaining medical treatment without asking about coverage and Network options; and, the DHS representative identified that phone numbers on the notice (when it was received) were listed in order for the appellant to contact the Agency and ask questions. DHS testified that the appellant never called for clarification. Any out of pocket expenses incurred which were not covered by Medicaid fee-for–service are the responsibility of the appellant, as the Agency was not at fault for any providers chosen out of Network. Any notice issues did not result in the appellant being wrongfully billed. Additionally, the notice, though possibly confusing, gave indication of Medicaid fee-for-service, and prospective enrollment in the United plan in the event the appellant was able to do so. The "dashboard" was generated immediately on May 29, and the appellant testified he used this to present to his providers. However, the more complete notice was generated on May 30, 2014 and was accessible on line, and sent to the appellant via the US postal service.

With regards to the appellant's contention that he had received prior authorization for PT services, he first submitted credible written testimony from LePre physical therapy which documented their perception of UHC's eligibility authorization for the appellant. A taped conversation later submitted by UHC documented the actual call between the PT facility and the UHC resolution specialist. The call demonstrated clearly that LePre Physical therapy representative made a good faith attempt to obtain prior authorization from UHC. LePre's inference that the services were covered, that no other authorization was needed, that the appellant who had been waiting for this authorization could begin, and that UHC could be billed directly-were reasonable and credible based upon the conversation. The responsibility for any clarification lay with the resolution specialist. The LePre representative's assumption that she had received eligibility authorization was well founded. Consequently, the appellant's understanding that his PT benefits could begin immediately was also a reasonable assumption. Accordingly, the appellant is not responsible for any PT bills and out of pocket PT expenses incurred as a result of UHC's misinformation or miscommunication. UHC is responsible for any remaining PT service bills for the month of June 2014 which have not been paid for by other

coverages. The total maximum amount in question at the time of hearing was $204.00 resulting from three $68.00 sessions in June-an amount adjusted by LePre.

After a careful review of the Agency's regulations, as well as the credible testimony given, the Appeals Officer finds that the appellant's request for relief is therefore granted in that he should have **some** of his medical expenses covered. Specifically, medical expenses incurred in June as a result of Physical therapy sessions, should be covered by his carrier-United Health Insurance.

ACTION FOR THE AGENCY:
United Health Care is responsible to reimburse the appellant for any out of pocket therapy payments made to LePre Physical therapy facility during the month of June 2014.

Karen Walsh
Appeals Officer

APPENDIX

MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)

1310 Rhody Health Program

1310.01 Overview

Rhody Health Partners (RHP) is a managed care delivery system for Medicaid eligible adults. Participants in Rhode Health Partners (RHP) are enrolled in a managed care organization (MCO), a type of health plan which uses a primary care provider to coordinate all medically necessary health care services through an organized delivery system. The Medicaid agency contracts with MCOs to provide these health services to members at a capitated rate or fixed cost per enrollee per month.
Adults eligible under this rule who have access to a Medicaid approved employer-sponsored health insurance plans are evaluated for participation in the RIte Share Premium Assistance Program and are required to enroll in an employer plan approved by the Medicaid agency as a condition of retaining Medicaid eligibility.

1310.02 Scope and Purpose

Effective on January 1, 2014, Rhode Island is implementing a new eligibility system for individuals and families seeking affordable coverage funded in whole or in part by Medicaid, tax credits and/or other public subsidies. The new system uses a single standard – modified adjusted gross income (MAGI) – to determine income eligibility for affordable coverage across populations. To facilitate the transition to the MAGI, the RI Medicaid agency has reconfigured these populations into four distinct Medicaid affordable care coverage groups (MACC GROUPs): families, pregnant women, Children and adults without dependent children. (See Medicaid Code of Administrative Rules (MCAR) Section 1301.03). Eligible members of the MACC group for adults without dependent children will be enrolled in a RHP health plan or, as applicable, RIte Share. The purpose of this rule is to describe the RHP delivery system for members of this MACC group and the respective roles and responsibilities of the Medicaid agency and the individuals receiving affordable coverage through RHP.

1310.05 MACC Group in Rhody Health Partners

The MACC group participating in RHP is adults, ages 19 to 64, who are not: pregnant, entitled to received Medicare Part A or B, or otherwise eligible for or enrolled in a Medicaid State Plan mandatory coverage group. (See MCAR Section 1301.05(05)).

1310.06 Overview of RHP

Individuals enrolled in RHP receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver, unless otherwise indicated. Covered services may be provided through the managed care plan or through the fee-for-service delivery system if the service is "out-ofplan" – that is, not included in the managed care plan but covered under Medicaid. Fee-for-service benefits may be furnished either by the managed care provider or by

any participating provider. Rules of prior authorization apply to any service required by Medicaid agency. Each RHP member selects a primary care physician (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care physician orders treatment determined to be medically necessary in accordance with MCO policies.

01. Access to Benefits – Unless otherwise specified, MACC group adults coverage groups entitled to a comprehensive benefit package that includes both in-plan and out-of-plan services. In-plan services are paid for on a capitated basis. The State may, at its discretion, identify other services paid for on a fee-for-service basis rather than at a capitated rate.

02. Delivery of Benefits – The coverage provided through the RHP is categorized as follows:

- **In-Plan Capitated Benefits, including: RHP Comprehensive Benefit Package; Special Services for Severely and Persistently Mentally Ill (SPMI)**
- **In-Plan Fee-for-Service Benefits**
- **Out-of-Plan Benefits**

03. Medical necessity – The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered services is required and appropriate. A "medically necessary service" means medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health related condition including any such services are necessary to prevent a decremental change in either medical or mental health status. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

1310.08 In-plan Fee-For-Services Benefits

The health plan or its approved providers will bill the Medicaid agency for fee-for-service for Medicaid State Plan and Section 1115 waiver covered in-plan benefits that have not been included in the capitated rate.

1310.09 Out-of-Plan Benefits

Out-of-plan benefits are not included in the capitated rate and are not the responsibility of the health plan to provide or arrange. These services are provided by existing Medicaid-approved providers who are reimbursed directly by the Medicaid agency on a fee-for- service basis. Out-of-plan benefits are provided to all RHP enrollees with the following exceptions: anyone enrolled in the guaranteed enrollment period but otherwise ineligible for Medicaid. The covered benefits are as follows:

Court-ordered services to out-of-network providers;

Routine dental services (emergency dental services are in-plan);

Family planning services. RHP recipients may seek family planning services either in-plan or from an out-of-plan provider. When members seek these services in-plan, the plan must provide them as part of its capitated benefit package and may not bill the State fee-for-service.

However, members are permitted to self-refer. For those individuals who elect to go out of network, the plan will reimburse the provider on a fee-for-service basis;

Seriously and Persistently Mentally Ill Adults & Seriously Emotionally Disturbed Children are provided Juvenile Drug Court Case Management Services (provided by Case Care Coordinators (CCP)).

1311:Enrollment Process: Rite Care and Rhody Health Partners Managed Care Plans

1311.01 Overview

With the approval of the State's Title XIX, Section 1115 waiver in 2009, enrollment in a managed care organization became mandatory for all individuals and families covered in the Rhode Island Medicaid program who do not require long term services and supports. The State's goal in implementing this policy is to assure that all Rhode Islanders enrolled in Medicaid have access to an organized system of high quality services that provides a medical home focusing on primary care and prevention services.

1311.02 Scope and Purpose

The Medicaid eligible Medicaid Affordable Care Coverage (MACC) groups identified in section 1301 of the Medicaid Code of Administrative Rules (MCAR) must enroll for coverage in a RIte Care (families, children and pregnant women) or Rhody Health Partners (adults 19-64 without children) managed care plan. There are other Medicaid coverage groups enrolled in both service delivery systems. This rule applies to all RIte Care coverage groups identified in section 1309 of the Medicaid Code of Administrative Rules (MCAR). It does not apply to adults eligible on the basis of age, blindness, or disability subject to the provisions for RIte Care and section 0374 of the MCAR for Rhody Health Partners for a description of these groups.

The Medicaid agency must ensure that enrollment in RIte Care and Rhody Health Partner (RHP) plans functions in a timely and efficient manner that respects the rights of Medicaid eligible individuals and families and the State's interest in assuring that they have ready access to an organized system of high quality health care. On January 1, 2014, the State will be implementing a new eligibility system for all new applicants for Medicaid in the MACC groups. The provisions of this rule identify the respective roles and responsibilities of the State – in this instance the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency – and the individuals and families eligible under all MACC, non-MAGI and non-Medicaid funded groups receiving coverage through RIte Care health plans, as identified in section 1309, and the MACC coverage group for adults eligible for the RHP plans, specified in section 1310.

The provisions of this rule also apply to any new applicants in these coverage groups who have access to employer-sponsored (ESI) health plans who may be qualified for the RIte Share premium assistance program on or after January 1, 2014, as specific in section 1312, until further notice from the Medicaid agency

1311.10 Identification Cards

Medicaid members are issued two identification cards – permanent health plan cards and permanent Medicaid cards.

01. Health permanent cards -- Medicaid health plans must issue permanent identification cards to all Medicaid members within fifteen (15) days of enrollment. The card identifies the plan name and a twenty-four hour, toll-free telephone number for the Medicaid member to call in the event of an urgent or emergent health care problem. The card also includes the telephone number for the plan's membership services division and the name and telephone number of the recipient's primary care physician.
02. Medicaid cards -- A Medicaid identification card is also issued to Medicaid members who are eligible for out-of-plan benefits through the State's Medicaid Management Information System (MMIS).

1311.11 Interim Fee-for-Service Coverage

There is a seven (7) day period between Medicaid health plan assignment and plan enrollment in which services provided to a Medicaid member may be paid for on a fee-for-service basis. The

services must be delivered to the Medicaid member by a health provider or practitioner certified to participate in the RI Medicaid program to qualify for the fee-for service payment. Services delivered prior to plan enrollment to a State-funded pregnant woman with income above 253% of the FPL are not covered.

1311.12 Verification of Eligibility/Enrollment

Medicaid health plans have the opportunity to contact the Medicaid agency or a DHS office or the automated eligibility verification system as necessary and appropriate to verify eligibility and plan enrollment if a Medicaid member requires immediate services.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.