0300 Rhode Island Medicaid Overview
October 2013

Overview and Statutory Authority of the State Agency

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

EOHHS is designated as the "single state agency", authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*), and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

Additionally, EOHHS possesses, among others, the following duties and responsibilities:

Lead the state's four (4) health and human services departments in order to:

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

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

Unless otherwise noted, the "state agency" referenced herein means EOHHS.

Applicability. The provisions in this section do not apply to the individuals and families in the Medicaid affordable care coverage (MACC) groups identified in MCAR section 1301 that take effect on January 1, 2014. The rule governing the application process for the Medicaid affordable coverage groups included in section 1301 are located in MCAR section 1303. **Accordingly, the provisions in this rule pertaining to individuals and families in the MACC groups outlined in section 1301 apply only to those who were enrolled and receiving Medicaid coverage prior to January 1, 2014, as specified.**

0300.05 Purpose of the Program
REV: October 2013

The Rhode Island Medicaid Program is the joint federal/state health care program that provides publicly funded health coverage to low income individuals and families, elders, and persons with disabilities who otherwise cannot afford or obtain the services and supports they need to live safe and healthy lives.

The Statutory foundations of the Rhode Island Medicaid Program are Title XIX of The Social Security Act, Rhode Island General Laws 40-8, and Rhode Island General Laws 42-7.2, as noted above.

0300.10 Program Administration
REV: October 2013

The Rhode Island Executive Office of Health and Human Services (EOHHS) is the agency of state government legally designated as the Medicaid single state agency. In this capacity, the EOHHS is responsible for administering the organization, financing, and delivery of Medicaid.

0300.15.10 Medically Needy
REV: October 2013

The Medically Needy are those individuals or families whose resources and/or income exceed the standards required for eligibility, but are within the Medically Needy standards. Applicants may achieve Medically Needy eligibility with a Flexible Test of Income which applies excess income to certain allowable medical expenses, enabling individuals or families to spend down to within Medically Needy income limits. In addition to meeting the income and resources criteria, Medically Needy recipients must also meet all non-financial requirements for Medicaid eligibility.

0300.20 Scope of Services
REV: October 2013

Medicaid recipients other than those who qualify as Medically Needy are entitled to the full scope of medical services provided by the Medicaid Program.

Recipients eligible as Medical Needy are entitled to a limited scope of medical services.

0300.20.05 Medical Services Provided
REV: October 2013

The medical services provided are:

MEDICAL SERVICES PROVIDED

Service	*Not Medically Needy*	*Medically Needy*
Inpatient Hospital Services	Yes 1,2	Yes 1,2 (see note below)
Inpatient Psychiatric Hospital	Yes	Yes Services for those age 65 and over or under age 21
Outpatient Hospital Services:	(see note below)	
Clinic and Emergency Room	Yes 1,3	No
Laboratory and X-rays	Yes	Yes
Physician Services	Yes 1,2	Yes 1,2
Pharmacy Services	Yes 8, 9, 10	Yes 8, 9, 10
Dental Services	Yes	Yes
Clinical Laboratory Services	Yes	Yes
Durable Medical Equipment, Appliances, and Prosthetic Devices	Yes	Yes 4 Surgical
Certified Home Health Agency	Yes	Yes Services
Podiatry Services	Yes	No
Ambulance Services	Yes	Yes
Community Mental Health Center	Yes	Yes Services
Substance Abuse Services	Yes 5	Yes 5
Nursing Facility Services	Yes	Yes
Optometric Services	Yes 6	Yes 7
Intermediate Care Facility and Services for the Mentally Retarded	Yes	Yes Day Treatment

NOTE: Inpatient hospital services are subject to admission screening and hospital utilization review procedures. Outpatient hospital services are subject to hospital utilization review procedures.

1. The cost of abortion service is paid only when it is necessary to preserve the life of the woman or when the pregnancy is the result of an act of rape or incest.

2. Organ transplant operations as described in section 0300.20.05.25 are Medicaid services.

3. A $3.00 co-payment is charged to eligible individuals for non-emergency services provided in a hospital emergency room.

4. Hearing aids and molded shoes are excluded.

5. Limited to counseling and Methadone maintenance services provided by centers licensed and funded by the Division of Substance Abuse of the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (DBHDDH).

6. For recipients age 21 and older, the following optometry services are limited to once every two years:

   a. one refractive eye care exam;

   b. one pair of eyeglasses (frames, lenses, dispensing fees).

7. For recipients age 21 and older, payment will be made for one refractive eye care exam in a two year period. Payment is not made for eyeglasses (frames, lenses, dispensing fees).

8. Individuals receiving Medicare Part A, Part B, and/or Part D will receive Pharmacy services through a Medicare Prescription Drug Plan.

9. Rhode Island Medicaid utilizes a preferred drug list.

If an individual requires a drug that is not listed on the preferred drug list, it is necessary for the individual to obtain prior approval from EOHHS. Procedures for submitting a request for prior approval authorizations are delineated in the Medicaid Provider Manual located on the EOHHS website at www.eohhs.ri.gov. Denials of a prior authorization are subject to the appeal process as stated in the General Provisions, Section 0110 of the DHS and Section 0110 of the EOHHS Rules.

0300.20.05.10 EPSDT
REV: October 2013

Title XIX of the Social Security Act provides for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of eligible Medicaid recipients under age 21 to ascertain physical and mental defects, and requires treatment to correct or ameliorate defects and medical conditions found. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) further mandates that under EPSDT, services will be provided for such other necessary health care, diagnostic services treatment, and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services, WHETHER OR NOT SUCH SERVICES ARE NORMALLY COVERED UNDER THE MEDICAID SCOPE OF SERVICES. Eligible individuals under age 21 receive Medicaid services consistent with EPSDT requirements.

0300.20.05.15 Abortions, Rape, or Incest
REV: October 2013

The cost of abortion services is paid when the pregnancy is the result of an act of rape or incest or it is necessary to preserve the life of the woman.

The following policy and procedure is to be followed when the pregnancy is a result of an act of rape or incest which will qualify for reimbursement by the Rhode Island Medicaid Program:

- The patient must provide a signed written statement attesting to the fact that the pregnancy is the result of an act of rape or incest. This requirement shall be waived if the treating physician certifies that in his or her professional opinion, the patient was unable for physical or psychological reasons, to comply with this requirement.

- The treating physician must provide a signed statement that she/he performed the termination of the pregnancy and that the pregnancy resulted from an act of rape or incest.

- The statements must be kept in the medical record for a period of three years to maintain an audit trail.

- The procedure must be performed by a licensed treating physician in a hospital setting or licensed out-patient facility.

0300.20.05.20 Abortions, To Save the Life of the Mother
REV: October 2013

Payment for an abortion will be rendered when a physician has found, and certified in writing to the EOHHS at the time payment for services is requested, that an abortion was medically necessary to save the life of the mother.

To qualify for reimbursement by the Rhode Island Medicaid Program for an abortion, the following policy must be followed in order to document medical necessity to save the life of a mother. (See section 0300.20.05.15 relative to payment for an abortion when the pregnancy is the result of an act of rape or incest.)

To receive Medicaid payment for services, the physician must:

- Be a doctor of medicine or osteopathy who is licensed to practice in the State of Rhode Island;

- Determine and certify in writing that in his/her professional judgment, the abortion was medically necessary to save the life of the mother;

- Retain a copy of the certification in the patient's medical record for a period of three years for purposes of audit;

- Submit a copy of the certification, which must contain the name and address of the patient, attached to the request for payment for services.

0300.20.05.25 Organ Transplant Operations
REV: October 2013

ORGAN TRANSPLANT OPERATIONS

The following organ transplant operations are provided as Medicaid services when medically necessary and when prerequisites are met:

- KIDNEY TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant.

- LIVER TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant.

- CORNEA TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant.

- PANCREAS TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant; evaluation at the transplant facility.

- BONE MARROW TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant.

- LUNG TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.

- HEART TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.

- HEART/LUNG TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.

- OTHER ORGAN TRANSPLANT OPERATIONS
  Such other organ transplant operations as may be designated by the Secretary of the Executive Office of Health and Human Services after consultation with medical advisory staff or medical consultants.

Medical Necessity

Medical necessity for an organ transplant operation is determined on a case-by-case basis using the following criteria: medical indications and contra-indications; progressive nature of the disease; existence of alternative therapies; life threatening nature of the disease; general state of health of the patient apart from the particular organ disease; any other relevant facts and circumstances related to the applicant and the particular transplant procedure.

Prior Written Approval

Prior written approval of the Secretary or his/her designee is required for all covered organ transplant operations. Procedures for submitting a request for prior approval authorizations are delineated in sections 200-30-1 through 200-30-5 of the Medicaid Program Provider Reference Manual.

0300.20.05.35 Pharmacy Services
REV: 09/2006

Under the Medicare Part D Program, in accordance with the Medicare Modernization Act of 2003, Medicaid beneficiaries who also receive Medicare Part A and or Part B, qualify for Part D and must receive their pharmacy services through a Prescription Drug Plan. Therefore, Medicaid beneficiaries who also receive Medicare benefits do not receive pharmacy benefits under the State Medicaid Program. There are, however, six (6) classes of drugs that are exempted from these drug plans and for which Medicaid will provide coverage under Medicaid Pharmacy Services to those receiving Medicare. The six (6) classes of drugs are: barbiturates, benzodiazepines, vitamins, over the counter medications, and cough and cold medications and covered weight loss medications. When purchasing these six (6) classes of drugs, Medicaid beneficiaries are required to pay a co-payment of one dollar ($1.00) for generic drug and three dollars ($3.00) for a brand name drug prescription.

0300.20.05.35.05 Pharmacy Services Cost Sharing Requirements
REV: 1/2014

Section 3309 of the Affordable Care Act amends section 1860D-14 (a)(1)(D)(i) of the Social Security Act (the Act) to extend elimination of Medicare Part D cost-sharing to full benefit dual eligible individuals who would be institutionalized if they were not receiving services under a home and community-based waiver authorized by a State under section 1115, or subsections (c) or (d) of section 1915, or under a State plan amendment under section 1915(i), or if such services are provided through enrollment in a Medicaid managed care organization with a contract under section 1903(m) or under section 1932.

Full dual beneficiaries receiving Home and Community Based Services (HCBS) must provide evidence of receipt of HCBS to their Part D plan sponsor. **Home and Community Based Services includes the following programs:** Preventive, Core Services, Personal Choice, Habilitation, Shared Living, Assisted Living and Division of Elderly Affairs (DEA) Programs.

0300.20.20 Waiver Programs
REV: October 2013

The Rhode Island EOHHS operates several programs under the 1115 Research and Demonstration Waivers. The 1115 Waiver allows beneficiaries to obtain the Medicaid services they need in the most appropriate least restrictive setting. The types of long-term care available to beneficiaries are categorized as institutional and home and community-based. To be eligible, a recipient must require the level of care provided in an institutional setting, and meet the eligibility criteria described in the specific Long Term Services and Supports program.

0300.20.25 Medicaid Payment Policy
REV: October 2013

Medicaid is the payor of last resort. Community, public and private resources such as Federal Medicare, Blue Cross/Blue Shield, VA benefits, accident settlements or other health insurance plans must be fully utilized before payment from the Medicaid Program can be authorized.

Payments to physicians and other providers of medical services and supplies are made on a fee for service basis in accordance with applicable federal and state rules and regulations, and established

rates of reimbursement governing the Rhode Island Medicaid Program. Payments to physicians and other providers of medical services and supplies represent full and total payment. No supplementary payments are allowed. Direct reimbursement to recipients is prohibited except in the specific circumstances set forth in Section 0302.30.10 to correct an erroneous denial which is reversed on appeal.

Payments for enrollment in a Rite Care Health Plan or a Rite Share approved employer based group health plan are made in accordance with policy contained in Section 0348.75.15 and 0349.30 respectively.

0300.20.30 Provider Deficiencies/Plan of Correction

REV: October 2013

The Rhode Island Department of Health surveys all Nursing Facilities (NF) and Intermediate Care Facilities/Mental Retardation (ICF/MR) for compliance with the federal participation requirements of the Federal Medicare Programs. As a result of these surveys, reports are issued for certification purposes which cite provider deficiencies, if any exist, together with appropriate plans of correction. Subsequent corrections of deficiencies are also reported.

Statements of provider deficiencies must be made available to the public through the Social Security Offices and Public Assistance Agencies. The Health Standards and Quality Bureau of the Regional Office transmits these reports in the following manner:

- **Nursing Facilities (NF**) - Reports are sent to the Social Security Administration (SSA) district office that covers the area in which the facility is located, and the Central Office of the Medicaid agency.

- **Intermediate Care Facilities/Mental Retardation (ICF/MR)** -
  Reports are sent to the Central Office of the Medicaid agency. The agency is required to send the reports for both Nursing and Intermediate Care Facilities/Mental Retardation to the appropriate Long Term Services and Supports (LTSS) Unit covering the district in which the facility is located. The agency must also send the ICF/MR reports to the SSA office covering the catchment area in which the facility is located.

These files are available to the public upon request. If an individual has questions about the reports, or requests additional data, the Supervisor will be informed and will contact the Chief Medical Care Specialist in the Long Term Services and Supports (LTSS) Unit at Central Office. Material from each survey will be held in the District Office for three (3) years and then destroyed.

0300.20.35 Medicare Premium Assistance Program
REV: October 2013

The Medicare Premium Assistance Program is a provision of the Medicaid program which allows Medicaid to pay for the Medicare Part A and/or Part B premiums of certain categories of Medicaid eligibles.

0300.20.40 Pharmacy Lock-In Program
REV: October 2013

The Code of Federal Regulations (CFR) at 42 CFR sec. 440.230(d) allows the Medicaid agency, or its contracted Managed Care Organization(s), to place appropriate limits on a medical service based on such criteria as medical necessity or on utilization control procedures. The Medicaid Pharmacy Lock-In Program has been established by the Medicaid agency to restrict recipients whose utilization of medical services is documented as being excessive. Recipients are "Locked-In" to specific providers in order to monitor services received and reduce unnecessary or inappropriate utilization. This program is intended to prevent Medicaid recipients from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

0300.20.40.05 Enrollment in Pharmacy Lock-In Program
REV: October 2013

Whenever Medicaid records indicate that recipient utilization is excessive or inappropriate with reference to medical need, the Medicaid agency, or its contracted Managed Care Organization(s), may require an individual to designate a physician and pharmacy of choice for exclusive service in order to:

- Protect the individual's health and safety;
- Provide continuity of medical care;
- Avoid duplication of service by providers;
- Avoid inappropriate or unnecessary utilization of Medicaid as defined by community practices and standards; and,
- Avoid excessive utilization of prescription medications.

Excessive utilization of prescription medications will be determined from published current medical and pharmacological references. The Medicaid agency or its contracted Managed Care Organization(s) selects for enrollment in the Medicaid Pharmacy Lock-In Program recipients who have a documented history of obtaining excessive or inappropriate prescribed drugs under the Medicaid Program.

Recipients will be given a written notice (MA/DUR-1 or similar notice from the specific health plan) of his/her excessive or inappropriate utilization thirty (30) days prior to the implementation of the restriction and will be asked to choose a primary pharmacy/physician as a single source of medical care.

The notification will also advise the individual that failure to cooperate in this program will necessitate the Medicaid agency’s designating a physician/pharmacy for the individual based on the recipient's previous use and geographical location.

The notification will include the individual's right to request a fair hearing within thirty (30) days if he/she disagrees with the findings and the Medicaid agency’s action.

0300.20.40.10 REVS Identification of Lock-In Recipients
REV: October 2013

Recipients who are in the Medicaid Pharmacy Lock-In Program are identified through the Recipient Eligibility Verification System (REVS).

0300.20.40.15 Primary Pharmacy of Choice
REV: October 2013

The Primary Pharmacy of Choice must monitor the drug utilization of each restricted recipient and must exercise sound professional judgment when dispensing drugs in order to prevent inappropriate drug utilization by the recipient. When the pharmacist reasonably believes that the recipient is attempting to obtain excessive drugs through duplicate prescriptions or other inappropriate means, the pharmacist must contact the providing physician to verify the authenticity and accuracy of the prescription presented. Primary pharmacies that are found on review to be dispensing drugs in a manner that is inconsistent with professional standards may be subject to administrative action by EOHHS or its contracted Managed Care Organization(s), including the recovery of payments.

0300.20.40.20 Primary Care Physician
REV: 05/1995

The Primary Care Physician is delegated the responsibility of overseeing the health care needs of the restricted recipient and providing all medically necessary care for which the recipient is eligible. The provider should be knowledgeable about the recipient's health care problems and aware of the care and services the recipient is receiving.

0300.20.40.25 Change in Primary Pharmacy/Physician
REV: October 2013

A recipient may change his/her primary pharmacy/physician for reasonable cause by notifying the Medicaid Pharmacy Lock-In Program or its contracted Managed Care Organization(s) and choosing a new primary pharmacy/physician.

0300.20.40.30 Change in Recipient Status
REV: October 2013

If, after review of the recipient's drug-usage profile, it is determined by the Medicaid Pharmacy Lock-In Program that restriction is no longer appropriate, the restriction will be removed. Such review will not take place prior to 15 months from the date of enrollment.

0300.25 Overview of Medicaid Eligibility Requirements
REV: October 2013

The eligibility requirements of the Medicaid Program are categorized as technical requirements, characteristic requirements, cooperation requirements, cost effectiveness and financial requirements.

0300.25.05 Technical Eligibility Requirements
REV: October 2013

Technical eligibility requirements for the Rhode Island Medicaid Program are citizenship, residence and possession of, or application for, a Social Security number.

Effective July 1, 2006, in conformance with the federal Deficit Reduction Act of 2005, both applicants and recipients for Medicaid are required to verify both citizenship and identity at the time of application for benefits or redetermination, if not previously verified.

To reduce barriers to eligibility for Medicaid Program applicants/recipients, the Medicaid agency will attempt to verify citizenship and identity via the State Verification and Exchange System (SVES) interface with the Social Security Administration. If the interface reveals a discrepancy or is unable to provide verification of citizenship or identity, it is the responsibility of the applicant/recipient to provide the required verification as detailed in Section 0304.05.10.05.

Applicants who do not comply with the requirement to verify both citizenship and identity will be denied Medicaid benefits. Recipients who do not comply with the requirement to verify both citizenship and identity will have their Medicaid benefits terminated.

0300.25.10 Characteristic Eligibility Requirements
REV: October 2013

Characteristics are non-financial eligibility factors. The required characteristics for an individual applying for Medicaid are those of the SSI program - age (65 or older), blindness or disability. For all other individuals and families, see sections 1301, 1303, and 1305 MCAR.

0300.25.15 Cooperation Requirements
REV: October 2013

As a condition of eligibility, the Medicaid applicant/recipient must meet certain cooperation requirements, such as providing the information needed for an eligibility determination, taking reasonable action to make income or resources available for support, assigning of rights to medical support or other third party payments for medical care, or pursuing eligibility for other benefits. Failure to cooperate may result in a denial of eligibility or case closure.

0300.25.20 Financial Eligibility Requirements
REV: 06/1994

Financial eligibility is based on the applicant/recipient's income and resources. Certain income and resources are COUNTABLE and thus included in the calculation of the individual's total income and resources to determine if financial eligibility exists. Other income and resources may be EXCLUDED from the calculation and not count toward the individual's allowable limit.

0300.25.20.05 Income Flex-Test and Spenddown
REV: October 2013

Medicaid policy provides that an otherwise eligible applicant with income in excess of the allowable income limits may be eligible for Medicaid if the excess income is insufficient to meet the cost of

certain medical expenses. An individual's unpaid medical bills and current receipts for incurred medical expenses may be subject to an Income Flex-Test. The applicant may qualify for an income spend down in which allowable medical expenses absorb his excess income, enabling him to qualify for Medicaid as Medically Needy.

0300.30 Methodology for Determining Coverage Group

REV: October 2013

A Coverage Group is a classification of individuals eligible to receive Medicaid benefits. There are numerous coverage groups distinguishable by income and resource standards and other nonfinancial criteria. An individual must satisfy all the requirements of at least one coverage group to be eligible for Medicaid. Medicaid coverage groups are categorized as SSI-related, family-related or special treatment coverage groups.

The term "SSI-related" refers to the methodologies used for evaluating the individual's income and resources, and the non-financial criteria to be met for Medicaid eligibility. Thus, an individual may be eligible for one of the SSI-related coverage groups if he/she is blind, disabled or age 65 or over, and has income and resources within the limits required for Medicaid eligibility. Some coverage groups in this category are referred to as "special treatment" coverage groups (e.g., QMBs, SLMBs, QIs, etc.).

Similarly, the term "family-related" refers to the methodologies for evaluating income, resources, and the non-financial criteria to be met for determining eligibility under family Medicaid coverage groups. Thus, if family members meet the required characteristics of Medicaid for families, then the countable income and resources are evaluated using the family-related methodologies.

Pregnant women, certain children and parent(s) of eligible children may qualify for Medicaid without possessing an SSI characteristic or a family characteristic of deprivation through the absence, death, incapacity or unemployment of a parent or caretaker relative. For example, a pregnant woman may be eligible for Medicaid without a deprivation characteristic or a resource test. For families, only Medically Needy eligibility, including Medically Needy eligibility based on spending down excess income, requires a deprivation characteristic.

Early in the application process an initial determination is made regarding the potential coverage group to which the Medicaid applicant may belong, usually based on the non-financial criteria of the coverage groups. Medicaid eligibility is then determined based on the applicable income/resource standards of the individual's particular coverage group.

If an applicant is a potential candidate for more than one coverage group, then the determination of Medicaid eligibility is made considering all possible coverage groups. The agency must allow an individual who would be eligible under more than one category to have his/her eligibility determined for the category he/she selects.

0300.40 Procedure for Imposing Administrative Sanctions

0300.40.05 Statutory Authority

REV: October 2013

In accordance with Title 42 Chapter 35 of the General Laws of Rhode Island (The Administrative Procedures Act), Title 40 Chapter 8.2, the Rhode Island EOHHS hereby establishes administrative

procedures to impose sanctions on providers of medical services and supplies for any violation of the rules, regulations, standards or laws governing the Rhode Island Medicaid Program. The Federal Government mandates the development of these administrative procedures for the Title XIX Medicaid Program in order to insure compliance with Sections 1128 and 1128A of the Social Security Act, which provides for federal penalties to be imposed for activities prescribed therein.

0300.40.10 Definitions
REV: October 2013

As used hereafter, the following terms and phrases shall, unless the context clearly required otherwise, have the following meanings:

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (U.S. Public Law 111-148); and the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-152), as amended.

Dual eligibles means Medicare beneficiaries who have limited income and resources who may get help paying for their out-of-pocket medical expenses from the state Medicaid program. For people who are eligible for full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under the state Medicaid program. Services that are covered by both programs will be paid first by Medicare and the difference by Medicaid, up to the state's payment limit.

Provider - any individual, firm, corporation, association, institution or group qualified or purporting to be qualified to perform and provide the medical services and supplies, which are within the scope of the services covered by the Rhode Island Medicaid Program.

Rhode Island Medicaid Program - established on July 1, 1966, under the provisions of Title XIX of the Social Security Act, as amended (P. L. 89-97). The enabling State Legislation is to be found at Title 40, Chapter 8 of the Rhode Island General Laws, as amended.

Secretary means the Rhode Island Secretary of the Executive Office of Health and Human Services who is responsible for the oversight, coordination, and cohesive direction of state administered health and human services, including the Medicaid agency, and for ensuring all applicable laws are executed.

State Agency means the Rhode Island Executive Office of Health and Human Services (EOHHS) which is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Title XIX Medicaid Program.

State Health Care Program - includes but not limited to those programs defined in section 1128 (h) of the Act such as those totally state-funded and administered by the Department.

Statutory Prerequisites - any license, certificate or other requirement of Rhode Island law or regulation which a provider must have in full force and effect in order to qualify under the laws of the State of Rhode Island to perform or provide medical services or to furnish supplies. The prerequisites include but are not limited to, licensure by the Rhode Island Department of Health, the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (DBHDDH),

certification for participation in the Federal Medicare Title XVIII Program and any other legal requirement pertinent to the delivery of the specific medical services and supplies. The term statutory prerequisite includes any requirement imposed by this Department through duly promulgated administrative regulations.

0300.40.15 Sanctionable Violations
REV: October 2013

All providers of medical services and supplies are subject to the general laws of the State of Rhode Island and the rules and regulations governing the Rhode Island Medicaid Program. Sanctions may be imposed by the Department against a provider for any one (1) or more of the following violations of applicable law, rule or regulation:

(i) Presenting or causing to be presented for payment any false or fraudulent claim for medical services or supplies.

(ii) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than to which the provider is legally entitled.

(iii) Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

(iv) Failure to disclose or make available to the Single State Agency or its authorized agent records of services provided to Medicaid recipients and records of payments made for such services.

(v) Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as determined by an official body of peers.

(vi) Engaging in a course of conduct or performing an act deemed improper or abusive of the Medicaid Program or continuing such conduct following notification that said conduct should cease.

(vii) Breach of the terms of a Medicaid provider agreement or failure to comply with the terms of the provider certification of the Medicaid claim form.

(viii) Over-utilizing the Medicaid Program by inducing, furnishing or otherwise causing a recipient to receive services or supplies not otherwise required or requested by the recipient.

(ix) Rebating or accepting a fee or portion of a fee or charge for a Medicaid recipient referral.

(x) Violating any provisions of applicable Federal and State laws, regulations, plans or any rule or regulation promulgated pursuant thereto.

(xi) Submission of false or fraudulent information in order to obtain provider status.

(xii) Violations of any laws, regulations or Code of Ethics governing the conduct of occupations or professions or regulated industries.

(xiii) Conviction of a criminal offense for any intentional, reckless, or negligent practice resulting in death or injury to patients.

(xiv) Failure to meet standards required by State or Federal laws for participation such as licensure and certification.

(xv) Exclusion from the Federal Medicare Program or any state health care program administered by the Department because of fraudulent or abusive practices.

(xvi) A practice of charging recipients or anyone in their behalf for services over and above the payment made by the Medicaid Program, which represents full and total payment.

(xvii) Refusal to execute provider agreement when requested to do so.

(xviii) Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from the Single State Agency.

(xix) Formal reprimands or censure by an association of the provider's peers for unethical practices.

(xx) Suspension or termination from participation in another governmental medical program such as Workers' Compensation, Children With Special Health Care Needs Program, Rehabilitation Services, the Federal Medicare Program, or any state health care program administered by the Department.

(xxi) Indictment for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

(xxii) Failure to repay or make arrangement for the repayment of identified overpayments or otherwise erroneous payments.

0300.40.20 Provider Sanctions
REV: October 2013

Any one (1) or more of the following sanctions may be imposed against providers who have committed any one (1) or more of the violations contained in Section 0300.40.15, above:

(i) Termination from participation in the Medicaid Program or any state health care program administered by EOHHS.

(ii) Suspension of participation in the Medicaid Program or any state health care program administered by EOHHS.

(iii) Suspension or withholding of payments.

(iv) Transfer to a closed-end provider agreement not to exceed twelve (12) months or the shortening of an already existing closed-end provider agreement.

(v) Prior authorization required before providing any covered medical service and/or covered medical supplies.

(vi) Monetary penalties.

(vii) Prepayment audits will be established to review all claims prior to payment.

(viii) Initiate recovery procedures to recoup any identified overpayment.

(ix) Except where termination has been imposed a provider who has been sanctioned may be required to attend a provider education program as a condition of continued participation in any health care program administered by EOHHS. A provider education program will include instruction in: (a) claim form completion; (b) the use and format of provider manuals; (c) the use of procedure codes; (d) key provisions of the Medicaid Program; (e) reimbursement rates; and (f) how to inquire about procedure codes or billing problems.

0300.40.25 Notice of Violations and Sanctions
REV: October 2013

When the Medicaid agency is in receipt of information indicating that a provider has committed a violation, and that provider is formally suspended or terminated, it shall forward by registered mail a notice of such violation to the provider. The notice shall include the following:

(i) A short and plain statement of the facts or conduct, which are alleged to warrant the intended departmental action. If the Medicaid agency is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved and detailed statement shall be furnished.

(ii) A statement of the provider's right to a hearing and that such a hearing must be claimed within fifteen (15) days of the receipt of the notice.

0300.40.30 Informal Hearing
REV: October 2013

Within fifteen (15) days after the receipt of a notice of an alleged violation and a sanction, the provider may request an informal hearing with the Medicaid agency.

This informal hearing will provide an opportunity for the provider to discuss the issues and attempt to come to a mutually agreeable resolution, thereby obviating the need for a formal administrative hearing. Informal dispositions may also be made of any contested case by stipulation, consent order, or default.

0300.40.35 Administrative Hearing
REV: October 2013

The right to an administrative appeal is conditioned upon the appellant's compliance with the procedures contained in these regulations and the hearing will be held in compliance with the provisions of the State's Administrative Procedures Act, as found at RIGL 42-35, as amended, and in conformance with DHS and EOHHS Policy Section 0110 et al.

0300.40.40 Appeal for Judicial Review
REV: 08/2007

Any provider who disagrees with the decision entered by the Hearing Officer as a result of the Administrative Hearing has a right to appeal for judicial review of the Hearing decision by filing a complaint with the Superior Court within thirty (30) days of the date of the decision in accordance with RIGL 42-35-15.

0300.40.45 Administrative Actions
REV: October 2013

Once a sanction is duly imposed on a provider, EOHHS shall notify the Rhode Island Department of Health (the licensing agent)and the Federal Medicare Title XVIII program if appropriate, state health care programs as defined in Section 1128(h) of the Social Security Act (as amended), state-funded health care programs administered by the Medicaid agency, or any other public or private agencies involved in the issuance of a license, certificate, permit or statutory prerequisite for the delivery of the medical services or supplies. Furthermore, EOHHS shall notify all affected Medicaid recipients.

0300.40.50 Stay of Order
REV: 08/2007

Orders may be stayed in accordance with RIGL 42-35-15 and 40-8.2-17.

0300.40.55 Reinstatement
REV: October 2013

(i) Pursuant to 42 CFR 1002.214 Subpart C, a state may afford a reinstatement opportunity to a state-initiated termination or suspension of any individual or entity. Such individuals or entities may be reinstated to the Medicaid Program only by EOHHS. The sanctioned individual or entity may submit a request for reinstatement to EOHHS at any time after the date specified in the notice of termination or suspension.

(ii) EOHHS may grant reinstatement only if it is reasonably certain that the types of actions that formed the basis for the original exclusion have not recurred and will not recur. Factors EOHHS will consider in making such a determination are contained in 42 CFR 1002.215(a)(l)(2)(3) Subpart C.

(iii) If EOHHS approves the request for reinstatement, it will provide the proper notification to the excluded party and all others in accordance with 42 CFR 1002.212 Subpart C. If EOHHS does not approve the request for reinstatement, it will notify the excluded party of its decision. Any appeal of a denial of reinstatement will be in accordance with state procedures and not subject to administrative or judicial review.

0300.45 Expedited Services

0300.45.05 Expedited Services Provision for Home And Community Based Services (H.C.B.S.)
REV: October 2013

Section 40-8.9-4 of the Rhode Island General Laws was amended in June 2007 to require the Medicaid agency to establish criteria for the purpose of accessing home and community care effective January 1, 2008. The funding for this mandate is from the added dollars realized from the cost savings from reductions in the number of nursing facility bed days from those projected to be used annually (including bed days used for persons utilizing the hospice benefit).

The Medicaid agency has instituted an Expedited Services provision in order to enable the temporary provision of specified Home and Community Based Services (HCBS) to those entrants to the publicly financed Long Term Services and Supports system who meet certain criteria and requirements, and who are deemed likely to be successful in their application for Long Term Services and Supports (LTSS) Medicaid.

Persons who are already in receipt of HCBS are not eligible for this Expedited Services provision. Receipt of LTSS Medicaid, Title XX home-care services, D.E.A. home-care services, P.A.C.E., Medicare home-care services, Visiting Nurse services, etc. are disqualifiers for the authorization of Expedited Services.

If there is a recognized Third Party Liability (TPL) opportunity, then the applicant is not eligible for Expedited Services. Trained and certified home and community-based service providers will be reimbursed for the provision of these Expedited Services to individuals who are pending a determination of LTSS Medicaid eligibility, ONLY IF that provider, and the individual they refer, successfully meet the requirements set forth in the following sections.

The HCBS services which are covered under this provision are authorized for up to twenty-one (21) days, and up to ten (10) hours weekly. Some subsequent extension may be possible after a review of the case. The Adult Day Care services which are covered under this provision are authorized for up to twenty-one (21) days, and up to three (3) days weekly. Some subsequent extension may be possible after a review of a case.

Payment for the HCBS so provided will cease upon the determination of the applicant's eligibility for Long Term Services and Supports Medicaid, or upon the twenty-first (21st)day of Expedited Services, whichever comes first. It is possible that in cases of pending applications, Expedited Services may be extended beyond the initial twenty-one (21) days. Successful LTSS Medicaid applicants will be transitioned onto the HCBS waiver program. Applicants who are denied LTSS Medicaid will immediately cease to be eligible for Medicaid agency payment for their Expedited Services.

Whenever the applicant is determined to be eligible for LTSS Medicaid, the expense incurred by the state for their HCBS under this provision will be submitted for standard Medicaid re-imbursement, back to the date of LTSS Medicaid eligibility.

It is important to note that this is NOT a determination of LTSS Medicaid eligibility. What is being determined is only whether the requirements for Expedited Services are met.

Applicants may be found eligible for Expedited Services, but subsequently be determined ineligible for LTSS Medicaid. (The reverse is also possible).

Note: Individuals may submit applications for Medicaid at any time during the month of application.

0300.45.10 Home & Community Based Services Covered
REV: October 2013

Persons who are already covered by LTSS Medicaid are NOT eligible for these Expedited Services. ONLY individuals who need to file a new application to obtain LTSS Medicaid can qualify for the provision of Expedited Services.

The services that are guaranteed temporary payment under this provision are:

1. Assistance to the applicant in obtaining, completing, and submitting a COMPLETE LTSS Medicaid application and supporting financial and medical documentation as specified by the R.I. DHS and EOHHS. Additionally, all the Expedited Service forms must be complete and submitted at the same time. Payment for this assistance is at a capped rate, established by the R.I. EOHHS.

NOTE: THE SERVICE OF ASSISTING WITH a new LTSS/Medicaid APPLICATION IS A PREREQUISITE FOR THE AUTHORIZATION OF ANY EXPEDITED SERVICE.

2. Homemaking services provided by a home health agency licensed to practice in Rhode Island at the established Medicaid rate.

3. Personal Care services provided by a home health agency licensed to practice in Rhode Island at the established Medicaid rate.

4. Adult Day Care services provided by a licensed Adult Day Care Provider at the established Medicaid rate.

0300.45.15 Provision for Receiving Expedited Services
REV: January 2014

Trained and certified providers will be reimbursed for these Expedited Services while a decision on the LTSS Medicaid application is pending under the following circumstances:

I. The provider has assisted the individual in completing, signing, and submitting a COMPLETE LTSS Medicaid application with all required financial and medical documentation to the R.I. DHS and EOHHS.

The application and documentation submitted must include or indicate the following:

1. No transfers of assets within the past five (5) years;

2. The applicant's income is:

   a. At or below one hundred percent (100%) of the Federal Poverty Level, or

   b. At or under three (3) times the Federal Benefit rate (in Sec. 0362.05) and the individual signs a DISCLAIMER AND AGREEMENT form, in which they acknowledge and accept the limitations of Expedited Services, and agree that all of the applicant's countable income over one hundred percent (100%) of the Federal Poverty Level must be contributed on a monthly basis towards the cost of these Expedited Services. Or

c. ONLY for individuals who are 65 years of more of age, a third option is available: (if the applicant's income is) in excess of three (3) times the Federal Benefit Rate, and the individual signs a DISCLAIMER and AGREEMENT FORM in which they acknowledge and accept the limitations of Expedited Services, and agree that all of the applicant's countable income over the Medically Needy Income Limit (MNIL) for one (1) one (less allowable deductions) must be contributed on a monthly basis towards the cost of these Expedited Services. (The MNIL is found in Sec. 0330.05).

3. A signed DISCLAIMER and AGREEMENT FORM MUST be included with ALL referrals for Expedited Services (even if they will not have to make any co-payment) in order to document their understanding of the limits of Expedited Services.

4. The bank statements and declared assets (excluding the primary residence, and one (1) car used for medical transportation) do not exceed $4,000 for an individual or $6,000 for a couple.

5. Only one (1) real estate property, the primary residence, with no more than $ 543,000.00 in equity value.

6. The individual meets citizenship/registered alien Medicaid or State funded Medicaid criteria.

7. The individual is a Rhode Island resident.

8. The applicant meets a categorical requirement of age (65 years of age or older), blindness or disability or is applying for permanent and total disability status through the Social Security Administration or the MART.

If disability has not been determined by Social Security through S.S.I. or R.S.D.I., or by the R.I. DHS Medicaid Review Team (MART), the Disability Determination forms as specified on the Expedited Services forms MUST ALSO be completed and returned with the referral for Expedited Services.

II. The provider submits ALL the completed Expedited Services FORMS as specified by the state.

The need for direct assistance, or supervision, in at least one Activity of Daily Living must be documented in the physician's form.

A Referral / Turn-Around form must indicate which service(s) is/are being requested.

Reimbursement for services is available from the date approval is granted for Expedited Services by DHS based on satisfactory completion of established criteria.

NOTE: If any of the above requirements are incomplete or missing, Expedited Services are automatically denied.

0300.45.20 Requirements for Reimbursement
REV: October 2013

I. **Certification of Providers of Expedited Services**

The payment for the Expedited Services listed in Section 0300.45.10 is only available to providers who have successfully completed a state training on the items and procedures necessary for a successful:

1. Long Term Services and Supports Medicaid application, and

2. Request for Expedited Services.

Certification for providers will be on a time-limited basis.

II. **Reimbursement of the Provision of Expedited Services:**

NOTE: PERSONS WHO ARE ALREADY IN RECEIPT OF ANY L.T.C. SERVICES (as specified in Sec. 0300.45.05) ARE NOT ELIGIBLE FOR THIS EXPEDITED SERVICES PROVISION. Reimbursement for the provision of Expedited Services, while the decision on the application for LTSS Medicaid is pending, is allowed in the following circumstances:

A. The provider has submitted to the state assigned staff a completed and signed Medicaid application with all required documentation as specified in 0300.45.15. These application materials MUST be received by the assigned state staff IN THE SAME MONTH THAT THE APPLICANT SIGNS the forms.

B. The provider must simultaneously submit to the state assigned staff ALL the COMPLETED forms required for Expedited Services, as specified by the state. These forms must document the need for direct assistance in at least one Activity of Daily Living or, the need for supervision by another person.

C. Payment is made for assistance in filing an application for LTSS Medicaid after the state's receipt of the completed LTSS Medicaid application, supporting documentation, and ALL fully completed Expedited Services forms. The service of assisting with a new LTSS/Medicaid application is a pre-requisite for the authorization of any Expedited Service.

NOTE: If in the course of assisting with the application, it becomes evident either:

1. That the applicant is obviously ineligible, or
2. That the obtaining/preparation of the materials required to qualify for Expedited Services will delay the filing of the application for LTSS/Medicaid, then the provider is required to forward the signed application to the appropriate LTSS office. No payment for Expedited Service will be made for applicants who are obviously ineligible, nor will payment be authorized when fulfilling the requirements of the Expedited Service process results in a delay of filing the application.

D. Reimbursement for the other Expedited Services is available from the date approval is granted for Expedited Services by the state, based on satisfactory completion of established criteria.

III. **R.I. Follow-Up Procedures**

A. The state assigned staff receives the entire request for Expedited Services and:

1. Date stamps the application and notifies the provider within two (2) business days of receipt whether the referral / application are acceptable or not acceptable for Expedited Services.
2. If the applicant is an SSI recipient, the state assigned staff confirms with the Office of Medical Review (OMR) whether or not they are active with Title XX services.
3. Enters the Expedited Services beneficiary into the Stop-Loss tracking system.
4. If Expedited Services are denied, the assigned state staff notifies the provider using a Referral /Turn-Around form.

B. The state assigned staff then utilizes a transmittal sheet to forward the entire LTSS application, including the physician's assessment, to the appropriate LTSS office.

C. Upon receipt of both the social worker's assessment and the physician's assessment, the Office of Medical Review is responsible for determining whether a Level of Care is met, following all established processes, and notifying the LTSS/AS/DEA worker assigned to the individual.

D. If ONLY Adult Day Care Services (ADCS) is authorized under Expedited Services, those requesting ADCS only will also be forwarded to the appropriate LTSS office for review:

1. If it appears that such an individual has a need for HCBS waiver services, AND might qualify for a "Level of Care" (LOC), the application is processed as an LTSS/Medicaid waiver application.

2. If that is not the case, then the LTSS office forwards all the received application materials to the appropriate state community Medicaid office, for the determination of eligibility according to the rules for Community based Medicaid.

E. For the cases they retain, the Long Term Services and Supports Office is responsible for:

1. Determining eligibility for LTSS Medicaid, following all established processes;

2. Forwarding appropriate cases to a DEA Case Management Agency for their usual development of an assessment, LOC, and creation of a case plan;

3. Retaining other appropriate cases for processing as usual for A+D waiver; and

4. Notifying the state assigned staff person.

F. The state assigned staff person tracks all received applications for determinations and is responsible for authorizing Stop-Loss payments, and removing payment authorizations under the Stop-Loss provision at the time when eligibility determinations are made.

0300.45.21 Severability
October 2013

If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.