State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1306:

Renewal of Eligibility for Medicaid Affordable Care Coverage Groups

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Rules and Regulations Section 1306:

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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1306 of the Medicaid Code of Administrative Rules entitled, "Renewal of Eligibility for Medicaid Affordable Care Coverage Groups"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

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

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in "Section 1306: "Renewal of Eligibility for Medicaid Affordable Care Coverage Groups" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State as a technical amendment on March 6, 2014.

1306 Renewal of Eligibility for Medicaid Affordable Care Coverage Groups

1306.01 Overview

One of the longstanding federal Medicaid policies is that eligibility must be redetermined once every year and the scope of these annual reviews must be limited to eligibility factors that are subject to change – income or residency, for example. State Medicaid agencies are also prohibited under federal Medicaid law from requiring beneficiaries to provide information unrelated to either continuing eligibility or a factor that is not subject to change, such as date of birth or United States citizenship. The onus for discontinuing Medicaid eligibility in this process thus falls to the State. The federal Affordable Care Act of 2010 not only reaffirmed these policies but took them a step further by requiring the states to automate continuing eligibility reviews to the full extent feasible and to recast the process as eligibility *renewal* instead of redetermination or recertification. Accordingly, effective January 1, 2014, the Medicaid agency is implementing a new automated eligibility renewal process for all individuals and families subject to the Modified Adjusted Gross Income (MAGI) standard set forth in section 1307 of Medicaid Code of Administrative Rules (MCAR).

1306.02 Scope and Purpose
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All Medicaid members will be subject to MAGI-based redeterminations, based on the requirements for the appropriate MACC group (MCAR section 1305), if there is a change in any eligibility factor. Such factors include changes in income, household composition or family size (e.g., due to death, marital status, birth or adoption of child), and/or immigration status. Disenrollments for any reason that are followed by requests for eligibility reinstatements are also subject to redeterminations through this process for members of the MACC groups irrespective of whether eligibility was established prior to or beginning on January 1, 2014.

1306.03 Limitations

The provisions of this rule do not apply to parents with income between from 133% to 175% of the Federal Poverty Level (FPL) who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

Medicaid-eligible individuals in non-MAGI coverage groups identified in MCAR 1301 are not subject to this rule and should refer to the redetermination requirements for their specific coverage group in the applicable sections of the MCAR.

1306.04 Definitions

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

"Active Renewal" means a method for determining continuing eligibility which requires the Medicaid beneficiary/member to take an action or engage directly with the Medicaid agency as a

condition of renewal. Includes requiring Medicaid members to reapply, provide written or electronic consent allowing access to protected personal information, and/or updating, signing and resubmitting pre-populated paper or on-line forms pertaining to eligibility factors.

"Enrollee" means a Medicaid member or beneficiary who is enrolled in a Medicaid managed care plan.

"Medicaid Affordable Care Coverage (MACC) Group" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014 as follows:

(01) Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

(02) Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

(03) Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

(04) Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

"Medicaid Code of Administrative Rules (MCAR)" means the compilation of rules governing the Rhode Island Medicaid program promulgated in accordance with the State's Administrative Procedures Act (R.I.G.L. §42-35).

"Medicaid member" means a person who has been determined to be an eligible Medicaid beneficiary.

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

"Navigator" means a person working for a State-contracted organization with certified assisters who have expertise in Medicaid eligibility and enrollment.

"New Applicant" means an individual or family who was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date of this rule. The term does not apply to individual and families who were receiving coverage and were disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

"**Non-MAGI Coverage Group**" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

"Passive Renewal" means a method for determining continuing eligibility that does not require the Medicaid member to take an action or engage directly with the Medicaid agency as a condition of renewal. Electronic review and verification of eligibility factors subject to change is conducted by using the Medicaid member's prior consent to access protected personal information. The Medicaid agency may require members to resolve discrepancies in pre-populated forms or on-line accounts.

1306.05 Responsibilities of the Medicaid Agency

It is incumbent on the Medicaid agency to ensure that Medicaid renewal process occurs at least once every twelve (12) months, and no more frequently than every twelve (12) months for all MACC group members. Toward this end, the Medicaid agency must meet the following requirements:

01. **Basis of Renewal** – The eligibility renewal must be based on information already available to the Medicaid agency to the full extent feasible. Accordingly, the Medicaid agency must use information about the Medicaid member from reliable sources including, but not limited to, the member's automated eligibility account, current paper records, or data bases that may be accessed through the federal data hub or the State's own affordable care coverage eligibility system (MCAR section 1308).

02. **Restrictions** – The Medicaid agency must not request or use information when conducting renewals pertaining to: eligibility factors that are not subject to change or concern matters

that are not relevant to continuation of Medicaid eligibility. Eligibility factors subject to change include income, household or family size, and immigration status. Factors that are not subject to change include, but are not limited to, U.S. citizenship, date of birth, and Social Security Number.

03. **Notice** – The Medicaid agency must provide timely notice of:

(01) **Renewal Date.** A notice of the date of the annual renewal must be sent at least thirty (30) days prior to the renewal date. The notice must provide the Medicaid member with information on the renewal process along with instructions on how to complete any actions that are conditions of renewal. A statement of the consequences for not taking necessary actions, if any, and the right to appeal and request an administrative fair hearing must also be included. As indicated in section 1306.05.04 below, the scope of the Medicaid member's direct participation in the process varies depending on whether the Medicaid agency is implementing an active versus passive approach to renewal.

(02) **Agency Action.** The Medicaid agency must provide Medicaid members with a notice stating the outcome of the renewal process and explaining the basis for any agency action. In instances in which continuation of eligibility depends on the Medicaid member taking action, such as providing paper documentation or reviewing information, the notice must state the nature of the action required, establish a timeline for completing the action and indicate the consequences for failure to do so, and indicate how the Medicaid beneficiary can obtain assistance from the Medicaid agency, whether through the representative of the Contact Center or the Department of Human Services (DHS) field offices. The right to appeal and request an administrative fair hearing in accordance with MCAR section 0110 must also be included.

03. **Consent** – The Medicaid agency must obtain the consent of the Medicaid member to retrieve and verify electronically information related to eligibility factors subject to change including any federal tax information required to review income eligibility. Such consent may be obtained during the initial application for Medicaid eligibility when the Medicaid member signs the application (see MCAR section 1303) under penalty of perjury or at the first time a Medicaid member is subject to a MAGI-based renewal.

04. **Renewal Strategy** – The Medicaid agency will use both active and passive renewal methods until all MACC group members have been subject to a MAGI-based income eligibility determination at least once. Accordingly, the Medicaid agency will conduct renewals as follows:

(01) **Active Renewals.** The Medicaid agency will use an active renewal method for all individuals and families who are seeking continuing eligibility using the MAGI standard for the first time. In this process, Medicaid members will be required to ensure the accuracy and completeness of any information on record related to an eligibility factor subject to change. In addition, the Medicaid member must provide consent to the Medicaid agency permitting automated retrieval of federal tax

information for income verification purposes for all subsequent renewals. A pre-populated form containing relevant eligibility information will be provided to the member to review and update and return with consent necessary to use passive method for future renewals.

(02) **Passive Renewals.** After the initial determination using the MAGI standard, whether at the time of application or first renewal, the Medicaid agency will use a passive renewal method. Medicaid members will be provided with timely notice of the annual renewal and a pre-populated form containing information about eligibility factors subject to change. The form will developed, with the Medicaid member's prior consent, by retrieving applicable protected personal information electronically to update eligibility records and conducting verification through the federal hub and State data bases. The Medicaid agency must advise the Medicaid member of the duty to report any changes related to these factors before the date of the annual renewal. Eligibility is continued unless such a report is received or any discrepancies that may surface in the data matches remain unresolved. Such changes may be self-reported through the eligibility system web-portal or in-person, via fax, on-line, or by mail or telephone with the assistance of a Contact Center or DHS agency representative, or Navigator.

05. **Enrollment** – A Medicaid member whose eligibility has been continued through the annual renewal process must remain in the same Medicaid health plan unless the renewal occurs during an open enrollment period. If an open enrollment process is not underway at the time of renewal, the provisions set forth in MCAR section 1311 prevail.

06. **Access** – The Medicaid agency must ensure that any application or supplemental forms required for renewal are accessible to persons who have limited proficiency in English or who have a disability.

1306.06 Responsibilities of Medicaid Members

Medicaid members must ensure that the Medicaid agency has access to accurate and complete information about any eligibility factors subject to change at the time of the annual renewal. Accordingly:

01. **Consent** – At the time of the initial application or first MAGI-based renewal, Medicaid members must provide the Medicaid agency with consent to retrieve and review any information not currently on record pertaining to the eligibility factors subject to change through electronic data matches conducted through the State's affordable overage eligibility system. Once such consent is provided, the Medicaid agency may retrieve and review such information when conducting all subsequent annual renewals.

02. **Duty to Report** -- Medicaid members are required to report changes in eligibility factors to the Medicaid agency within ten (10) days from the date the change takes effect. Self-reports are permitted through the eligibility system on-line portal. Medicaid members also may report such changes in person, via fax, by mail, or telephone with the assistance of

Contact Center or DHS agency representative, or Navigator. Failure to report in a timely may result in the discontinuation of Medicaid eligibility.

03. **Cooperation** – Medicaid members must provide any documentation that otherwise cannot be obtained related to any eligibility factors subject to change when requested by the Medicaid agency. The information must be provided within the timeframe specified by the Medicaid agency in the notice to the Medicaid member stating the basis for making the agency's request.

04. **Voluntary Termination** -- A Medicaid member may request to be disenrolled from a Medicaid health plan or to terminate Medicaid eligibility at any time. Disenrollment results in the termination of Medicaid eligibility. Once Medicaid coverage is terminated, the penalties established under the individual mandate in the federal Affordable Care Act of 2010 apply unless the former Medicaid member obtains an alternate form of health insurance coverage.

05. **Reliable Information** – Medicaid members must sign under the penalty of perjury that all information provided to the Medicaid agency at the time of application and any annual renewals thereafter is accurate and truthful.

1306.07 Information
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For Further Information or to Obtain Assistance

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

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

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1306.08 Severability

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