State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1311:

Enrollment Process: RIte Care and Rhody Health Partners Managed Care Plans

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Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1311:

Enrollment Process: RIte Care and Rhody Health Partners Managed Care Plans

TABLE OF CONTENTS

Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1311 of the Medicaid Code of Administrative Rules entitled, "Enrollment Process: RIte Care and Rhody Health Partners Managed Care Plans"** 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 1311 of the Medicaid Code of Administrative Rules entitled, "Enrollment Process: RIte Care and Rhody Health Partners Managed Care Plans" 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.

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.

1311.03 Definitions

"**Employer sponsored insurance (ESI**)" means health insurance or a group health plan offered to employees by an employer. This includes plans purchased by small employers through HealthSourceRI.

“Enrollee” means a Medicaid member (sometimes referred to as a Medicaid “beneficiary”) enrolled in a Medicaid managed care plan.

“Managed Care Organization (MCO)” means a health plan system that integrates an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and place emphasizes preventive and primary care.

“**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.

“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.

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

“**Prospective Medicaid enrollee”** means an individual or family that has been determined eligible for Medicaid, but has not enrolled in a RIte Care or RHP plan.

“**Rhody Health Partners”** means the Medicaid managed care delivery system providing affordable health coverage to eligible adults without dependent children, ages 19 to 64, under section 1310 and adults with disabilities eligible under section 0374.

“**RIte Care**” means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age 19, and young adults older than age 19 (see section 1309 of the Medicaid Code of Administrative Rules).

“RIte Share” means the Medicaid premium assistance program for eligible individuals and families who have access to cost-effective commercial coverage.

1311.04 Initiating Enrollment: No Wrong Door

The enrollment process begins at the point in which an eligibility determination has been made and the applicant is notified. Once determined eligible, a Medicaid member must select a plan at the time a determination is made if applying on-line through the web-portal either alone or with assistance. Notice of eligibility provided by the Medicaid agency, whether electronically or on paper, must inform the Medicaid member of whether enrollment in a RIte Care versus Rhody Health Partners plan is required. The Medicaid coverage group that is the basis of eligibility for an individual or family determines the delivery system – RIte Care or RHP – in which a person must enroll (see MCAR section 1301).

01. Enrollment channels --Once determined eligible, a Medicaid eligible person may enroll in a RIte Care or Rhody Health Partners Plan, as appropriate:

(01) Online through the eligibility portal independently or with a navigator's assistance;

(02) Over the phone with a Contact Center representative; or

(03) In-person at the Contact Center or a DHS office. (Contact information located in section 1311.25)

02. Information on enrollment options - The Medicaid agency and the RIte Care and RHP plans share responsibility for ensuring Medicaid applicants and prospective and current enrollees have access to accurate up-to-date information about their enrollment options. This information is available on-line if applying through the eligibility web portal, as well as through the Contact Center, the Medicaid agency, DHS and the participating plans. The information available must include:

- Materials describing the Medicaid managed care delivery system.
- A written explanation of enrollment options including information about the applicable service delivery system – RIte Care versus RHP – and choice of participating health plans health plans therein.
- Upon requested, an indication of whether a prospective enrollee’s existing physician is a participant in each of the respective plans.
- Non-biased enrollment counseling through the Contact Center or a Navigator.
- A chart comparing participating plans.

- Detailed instructions on how to enroll.

- Full disclosure of any time limits and consequences for failing to meet those time limits.

- Access to interpreter services.

- Notification in writing of the right to challenge auto-assignment for good cause through the Medicaid agency.

01. Non-biased enrollment counseling -- Non-biased enrollment counselors who are not affiliated with any participating plan help enrollees choose a managed care plan and a primary care provider (PCP) capable of meeting their needs. Factors that may considered when making this choice are whether an existing PCP participates in a particular plan as well as language preferences or limitation, geographic proximity, and so forth. Enrollment counselors are available by telephone or in-person at the Contact Center and DHS offices during regular hours of operation. They also are available in-person and by telephone at these locations to assist enrollees who would like to change health plans (e.g., during open enrollment or due to good cause).

02. Voluntary selection of health plan -- Prospective enrollees are given fourteen (14) calendar days from the completion of their eligibility determination to select a health plan. All members of a family must select the same health plan. If an individual or family does not select a health plan within the time allowed, the individual or family is automatically assigned to a health plan.

03. Automatic assignment into health plan -- The State employs a formula, or algorithm, to assign prospective enrollees who do not make a voluntary selection into a health plan. This algorithm considers quality and financial performance.

04. Requests for reassignment – Medicaid enrollees may who have selected a plan voluntarily or have been auto-assigned may request to be reassigned within certain limits. Such requests are categorized as follows:

(01) Requests made within ninety (90) days of enrollment. Medicaid members may be reassigned to the health plan of their choice if their written request for reassignment and their choice of an alternative plan is received by the Medicaid agency within ninety (90) days of the voluntary or auto-assigned enrollment and the plan selected is open to new members.

(02) Requests made ninety (90) days or more after enrollment. Medicaid enrollees who challenge an auto-assignment decision or seek to change plans more than ninety (90) days after enrollment in the health plan must submit a written request to the Medicaid agency

and show good cause, as provided in section 1311.07, for reassignment to another plan. A written decision must be rendered by the Medicaid agency within ten (10) days of receiving the written request and is subject to appeal.

05. Auto-assignment and resumption of eligibility – Medicaid members who are disenrolled from a health plan due to loss of eligibility are automatically re-enrolled, or assigned, into the same plan if they regain eligibility within sixty (60) calendar days. If more than sixty (60) days have elapsed, the Medicaid member is permitted to select a plan from those open for enrollment at that time.

06. Open-enrollment – To the extent feasible, the Medicaid agency must coordinate open enrollment periods with those established for affordable care more generally through the State's health insurance exchange – HealthSourceRI.

07. The Medicaid agency reserves the discretion to provide Medicaid wrap around coverage, as an alternative to coverage in a Medicaid managed care plan to any eligible individual who has comprehensive health insurance through a liable third party, including (but not limited to) absent parent coverage. Such wrap around coverage must be equivalent in scope, amount and duration to that provided to Medicaid eligible individuals enrolled in in a qualified health plan, including ESI, through the RIte Share program (MCAR section 1312).

1311.05 Enrollment of Newborns and Adopted Children

The enrollment of infants born to mothers who are Medicaid eligible varies depending on the mother's coverage group. Enrollment of adopted children who are eligible on their own or as part of a Medicaid eligible family also varies depending on the basis of Medicaid coverage.

01. Newborns – Infants born to mothers with income less than 253% of FPL who are enrolled in a health plan on the date of their baby's birth are automatically enrolled into a RIte Care health plan. If the newborn's mother is in enrolled in a RIte Care plan, the child is automatically enrolled in the mother's health plan. If the newborn's mother is enrolled in a RHP health plan, the baby and the mother will be enrolled in a RIte Care health plan, effective on the date of birth, once certification of the birth has been received. If the newborn's mother is enrolled in an ESI or other qualified health plan (QHP) with a Medicaid wrap, the baby is enrolled in RIte Care or RIte Share if the plan meets the cost-effectiveness test set forth MCAR section 1312. See MCAR section 1305 for newborn deeming provisions.

02. Adopted children -- Legally adopted children are enrolled as of the date the adoption becomes final. This date cannot be prior to the date Medicaid eligibility is established. The applicable provisions on eligibility and enrollment of child participating the State's adoption subsidy program are located in MCAR section 0342. A parent, caretaker or guardian must notify the Medicaid agency when a newborn deemed eligible is adopted.

03. Other Infants and Children -- All infants and children with income up to the 261% of the FPL level are Medicaid eligible under the MACC group for children and young adults, irrespective of the a eligibility of a parent, caretaker or pregnant mother as indicated in the provisions in MCAR section 1301. Any infants and children determined eligible on this basis are enrolled in a RIte Care or, as applicable, RIte Share-approved ESI health plan in accordance with the provisions of this rule applicable to all other Medicaid members.

1311.06 Medicaid Members Exempt from Enrollment Managed Care

Certain Medicaid members who would otherwise receive care through the RIte Care or RHP delivery systems may be granted exemptions from mandatory enrollment in a managed care health for good cause in narrow range of “extraordinary circumstances” upon approval of the Medicaid agency. An extraordinary circumstance, as defined for these purposes, is a situation, factor or set of factors that preclude a Medicaid member from obtaining the appropriate level of medically necessary care through the managed care delivery system -- RIte Care or RHP – designated for the Medicaid member’s coverage group.

01. Types of extraordinary circumstances -- Such a situation, factor or set of factors may include the existence of a chronic, severe medical condition for which the member has a longstanding treatment relationship with a licensed health care practitioner – e.g., primary physician, specialist, etc -- who does not participate in any of the Medicaid health plans in the delivery system designated to provide care to the member.

02. Limits -- A Medicaid member's preference to continue a treatment relationship with a particular physician or other health care practitioner who does not participate with a heath plan in the member’s designated delivery system does not constitute an "extraordinary circumstance" in and of itself.

03. Exemption requests – Requests for exemption to mandatory enrollment in managed care due to extraordinary circumstances must be made in writing, include appropriate documentation (letter from physician, medical records, or other as indicated), and signed. Exemption requests should be routed to the Medicaid agency.

04. Agency actions and duration of exemption --The Medicaid agency makes enrollment exemption determinations based on a consideration of the circumstances of each member’s individual request. Once exempted, an individual can be exempt for as long as the extraordinary circumstance exists. Non-exempt Medicaid members in a household must follow the regular Medicaid health plan enrollment process.

1311.07 Health Plan Lock-In

Following initial enrollment into a plan, Medicaid members are restricted to that plan until the next open enrollment period. During this health plan lock-in, a Medicaid member may only be disenrolled under one of a set of specific allowed conditions.

01. Allowed conditions for disenrollment requests -- Members may request disenrollment for any of the following reasons:

    - Substandard care;
    - Inadequate access to necessary specialty services;
    - Insufficient transportation;
    - Discrimination;
    - Member relocation;
    - Good cause as defined in sections 1311.07 and 1311.19.03
    - Without cause during the ninety (90) days following the effective date of the Medicaid member's initial enrollment with the health plan.

02. Filing an appeal – Medicaid members seeking disenrollment during the lock-in period must first file a formal appeal in accordance with the grievance and appeal procedures of the health plan (see MCAR section 0110).

03. Agency review -- Disenrollment can only be ordered by the Medicaid agency after administrative review of the facts of the case. In the course of the review, the Medicaid agency must examine the evidence compiled by the health plan about the grounds that are the basis for the Medicaid member's request for disenrollment.

04. Notice of agency action – The Medicaid agency must provide the member with written notice of the action taken on the request for disenrollment. If the Medicaid agency determines that there is sufficient evidence to disenroll the Medicaid member, the notice must be sent to the member at least ten (10) days prior to the date the proposed disenrollment would be effective. The Medicaid member must meet with an enrollment counselor to select another health plan.

1311.08 Open Enrollment

During an open enrollment period, Medicaid members have an opportunity to change health plans. Open enrollment extends to all RHP enrollees and RIte Care enrollees with the exception of members in the Extended Family Planning coverage group.

1311.09 Membership Handbook

The Medicaid health plan must provide a Medicaid enrollee with a membership handbook and information on how to select a primary care physician member. This information must be sent by mail within ten (10) days of the date of plan enrollment for all members excluding foster children. The plan must send this same information to foster children within fifteen (15) days of the date of enrollment.

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.

1311.13 Responsibility of Medicaid Members to Report Change in Status

Medicaid members are responsible for reporting certain changes in status including any related to family size, residence, income, employment, third party coverage, and child support. A status change form must be filed with the Medicaid agency, the Contact Center or a DHS field office within ten (10) days of the date the change takes occurs. In addition, the Medicaid agency conducts periodic reviews to determine whether any changes in status have occurred that affect eligibility or health plan enrollment. Medicaid health plans must also report to the Medicaid agency any changes in the status of Medicaid members once they become known.

1311.14 Renewals of Continuing Eligibility

Repealed June 2014

1311.15 Transitioning Members between Health Plans and Delivery Systems

It may be necessary to transition a Medicaid member between health plans or from one delivery system -- RHP to RIte Care or vice versa -- for a variety of reasons:

01. Change in plans within a delivery system – The transition between Medicaid health plans may occur as a result of change in health plan during open enrollment or a change that is ordered as part of a grievance resolution. The health plans have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when transitioning a member to or from another plan. The health plan must transfer this information at no cost to the member.

02. Change in delivery systems – Medicaid members may be transitioned from one managed care delivery system into another as a result of changes in eligibility status. Adults enrolled in RIte Care who are between the ages of 19 and 64 may be eligible under the MACC group for adults when their dependent children age out of MACC group for children and young adults. Once a RHP member has given birth, both newborn and/or parents may be transitioned to RIte Care if income is within the eligibility thresholds set forth in 1301. Enrollment in health plans during such transitions will strive to preserve the continuity of care to the full extent feasible. Accordingly, Medicaid members enrolled in a particular plan subject to a delivery system transition will be enrolled in the same health plan, if participating, in the new delivery system.

1311.16 Grievance and Appeals

The State provides a grievance and appeals process that health plan providers and Medicaid enrollees must use when seeking redress against health plans. This is the same process that the health plans must use when seeking to disenroll members who are habitually non-compliant or who pose a threat to plan employees or other members. This process has multiple components that extend from complaint resolution to the filing of formal appeals.

01. Internal complaint resolution --The health plans resolve member and provider complaints through internal mechanisms whenever possible. The health plans therefore must maintain written policies and procedures for resolving member complaints and for processing grievances either upon request or when the time allotted for complaint resolution expires. This information must be included in the member handbook distributed to enrollees by the Medicaid health plans and provided to the public upon request.

02. Timeliness -- The health plan may take up to fifteen (15) days to seek resolution of a medical care related complaint and up to thirty (30) days to seek resolution of a non-medical care related complaint. If a complaint is not resolved to the satisfaction of the member or provider within the allotted time, the health plan must agree to automatically register the complaint as a formal grievance, unless requested otherwise by the member or provider. The health plan also must agree to register a complaint as a formal grievance if requested to do so at any time by the member or provider, even if the fifteen (15) or thirty (30) day limit has not been reached. In addition, the health plan must comply with the initial and second level appeals process as described in Rhode Island's *Rules and Regulations for the Utilization Review of Health Care Services.*

1311.17 Member/Provider Initiated Formal Grievances

The health plans maintain internal policies and procedures to conform to State reporting policies and provide a process for logging formal grievances. RIte Care and RHP members must exhaust the internal health plan appeals process before requesting an EOHHS Administrative Fair Hearing. Appeals filed with a health plan fall into three (3) areas:

01. Medical Emergency - A health plan must decide an appeal of a policy within two (2) business days when a treating provider, such as a doctor who takes care of the member, determines the need for care to be an emergency and all necessary information has been received by the health plan.

02. Other Medical Care - There are two (2) levels of a non-emergency medical care appeal.

(01) Initial level of appeal. The Medicaid health plan must decide an appeal within fifteen (15) days of the date that all necessary information has been received by the plan. If the initial decision is against the member, then the health plan must offer the second level of appeal.

(02) Second level of appeal. The health plan must decide on the grievance within fifteen (15) days of the date that all necessary information has been received by the plan.

RIte Care and RHP members may also choose to initiate a third (3rd) level or external appeal, per the Department of Health *Rules and Regulations for the Utilization Review of Health Care Services* (R23-17.12-UR). A member does not have to exhaust the third level appeal before accessing the EOHHS administrative fair hearing process.

3. Non-Medical Care - If the grievance involves a problem other than medical care, the health plan must decide the grievance within thirty (30) days of the date that all necessary information has been received by the health plan. Medicaid members must exhaust the internal health plan appeals process in these cases before requesting an EOHHS Fair Hearing. Regulations governing the appeals process are found in section 0110 of the MCAR.

1311.18 Health Plan Initiated Disenrollment

The health plan may seek disenrollment of a member who is habitually non-compliant or poses a threat to health plan employees or other members. A health plan initiated disenrollment, is subject to an administrative review process by the Medicaid agency and must follow the following requirements:

01. Health plan disenrollment requests -- For a plan to disenroll a Medicaid member, the plan must send a request, along with accompanying documentation, to the Medicaid agency. When the request is received, the Medicaid agency sends a notice to the Medicaid member informing him or her that the plan is seeking to take a disenrollment action and explaining the reason given by the plan for taking such an action. The notice also informs the member that of the right to submit within ten (10) days any evidence establishing a good cause appeal rejecting the disenrollment action.

02. Medicaid agency action -- The Medicaid agency must investigate and render a decision within ten (10) days of receipt of evidence from both parties. The Medicaid agency's decision is subject to appeal. If, based upon the evidence submitted by the health plan, the Medicaid agency determines that the Medicaid member should be disenrolled from the health plan, a notice is sent to the Medicaid member by the Medicaid agency stating the decision and the basis thereof at least ten (10) days prior to the date the proposed disenrollment would be effective.

03. Good Cause appeal -- A Medicaid member subject to a health plan request for disenrollment has the right to present evidence establishing good cause. Good cause must be filed prior to the

end of the ten (10) day advance notice period. The filing of good cause is submitted in writing to the Medicaid agency. Good cause includes circumstances beyond the Medicaid member's control sufficiently serious to prevent compliance; an unanticipated household emergency; a court-required appearance; incarceration; breakdown in transportation arrangements; or inclement weather which prevented the Medicaid member and other persons similarly situated from traveling to, or participating in, the required appointment. A member's preference to remain in fee-for-service does not constitute good cause for an appeal of the request for disenrollment.

1311.19 Medicaid Agency Authority

EOHHS has sole authority as the Medicaid Single State Agency for disenrolling Medicaid members from a health plan. Requests for disenrollment, either as the result of a formal grievance filed by the Medicaid member against the health plan, or by the health plan against the Medicaid member, is subject to an administrative review process by the Medicaid agency.

1311.20 Reasons for Disenrollment

EOHHS may disenroll Medicaid eligible health plan members for a variety of reasons including, but not limited to, any of the following:

- Death;
- Loss of eligibility;
- Selection of another health plan during open enrollment;
- Change of residence outside of the plan's service area;
- Non-payment of premium share;
- Incarceration;
- Permanent placement in Eleanor Slater Hospital;
- Long-term placement in a nursing facility for more than thirty (30) days;
- Disenrollment as the result of a formal grievance filed by the member against the health plan; or
- Disenrollment as the result of a formal grievance filed by the health plan against the member.

1311.21 Disenrollment Effective Dates

Member disenrollments outside of the open enrollment process become effective on the date specified by the State, but not fewer than six (6) days after the health plan has been notified, unless the health plan waives this condition. The health plans have written policies and procedures for complying with State disenrollment orders.

1311.22 Right to Appeal

All notifications of disenrollment must include information regarding the Medicaid member's right to appeal the decision and the procedures for requesting an EOHHS administrative fair hearing.

1311.23 EOHHS Hearings

See MCAR section 0110.

1311.24 Medicaid Member Rights and Protections

All Medicaid members are guaranteed access to quality health care delivered in a timely and respectful manner. To ensure this goal is met, the following rights and protections must be clearly stipulated by both the Medicaid agency and the health plan.

01. Enrollment -- The Medicaid agency will make every effort to provide the following:

- Multilingual services to all people who do not speak English;
- Written enrollment information will be provided in a clear and easy-to-understand format;
- Enrollment information provided by the plan must include detailed information on how to obtain transportation services, second opinions, interpreter services, referrals, emergency services and out of state services unavailable in Rhode Island. Information must also be provided regarding switching primary care providers, disenrollment for good cause, the in-plan grievance process and the EOHHS appeals process;
- The State will conduct a special enrollment outreach effort for beneficiaries who are homeless or who live in transitional housing;
- Once a Medicaid member is enrolled, the health plan will conduct a special enrollment outreach effort for any enrollees who are homeless or who live in transitional housing;

- The health plan is prohibited from engaging in any door-to-door or telemarketing or any other similar unfair marketing practices;

- Enrollees will be provided with counseling assistance in the selection process for their primary care providers;

- Medicaid members who receive on-going care from a primary care provider or specialist will be advised by the non-biased enrollment counselor which providers are participating in each health plan option so as to promote continuity of care;

- If a Medicaid member is auto-assigned to a health plan, the member may dispute that assignment through the right to rebuttal. A decision by the Medicaid agency must be rendered within ten (10) days of the filing of the rebuttal and is subject to appeal.

02. Second Opinions and Switching Doctors – Every Medicaid member must be informed of the following:

- Health plans must provide, at their expense, a second opinion within the health plan upon an enrollee's request. A decision on the request for a second opinion will be made in a timely manner and approval shall not be unreasonably withheld;

- Health plans must provide a second opinion by a qualified, non-participating provider when the plan determines that an enrollee's chemical dependency or mental health problem does not require treatment;

- A Medicaid member is entitled to a second surgical opinion by a plan physician, or if the referral is made by a plan physician, to a second surgical opinion by a non-participating physician;

- Medicaid members have the right to switch providers within the plan, upon request. Reasons for switching providers include the following: substandard care; problems with language or communication; discrimination; rude treatment or personality conflicts with providers or provider staff; moving or good cause;

- Members who are denied a second opinion or denied the right to switch providers will have the right to appeal under the grievance procedures as listed below.

03. Grievance Procedures – Medicaid members must also be informed of their rights including the following:

- The right to appeal the following decisions: assignments to providers; referrals; denial of services; and determinations of non-emergency care;

- The right to a timely in-plan grievance procedure;

- The right to a timely fair hearing from the Executive Office of Health and Human Services. (See section 0110 of the MCAR);

- Grievances filed with health plan that relate to medical treatment must be decided within fifteen days.

04. Disenrollment – The following apply to requests for disrenrollment, as indicated:

- Medicaid members may request to disenroll from any health plan for the remainder of an enrollment period for any of the reasons established in section 1311.18;

- A rapid disenrollment process must be provided for individuals and families who are dislocated and move to another area due to homelessness, domestic abuse, or other similar crises, if they cannot access in-plan services within a reasonable distance from their new location;

- Medicaid members who are disenrolled have a right to appeal that decision through the EOHHS administrative appeals process as outlined in section 0110 of the MCAR general provisions.

05. Interpreter Services --Plans are encouraged to provide availability to twenty-four (24) hour interpreter services for every language group enrolled by the health plan for all points of contact, especially telephone contact. In addition, reasonable attempts must be made by the plans to have written materials, such as forms and membership manuals, translated into other languages. If the health plan has more than fifty (50) members who speak a single language, it must make available general written materials, such as its member handbook, in that language. Interpreter services are provided if a plan has more than one hundred (100) members or ten percent (10%) of its Medicaid membership, whichever is less, who speak a single language other than English as a first language.

06. Exceptions Based on Safety Needs -- Providers, health plans and the State must consider the personal safety of a client in instances of domestic violence in all of the following matters:

    - Enrollment policies;

    - Disenrollment policies;

    - Second opinions;

    - Switching primary care physicians/practitioners; and

- Grievance procedures.

07. Referral to Rhode Island Legal Services -- Notices to Medicaid members must include the information indicated that they may represent themselves or be represented by someone else such as a lawyer, relative, or another person in the hearing and appeal process. Notices must also information regarding free legal help being available by calling Rhode Island Legal Services.

1311.25 Information
REV: March 2014

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).

1311.26 Severability

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