State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1301:

Medicaid Affordable Care

Coverage Groups

December 2013
March 2014 (T)
March 2015

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage under the Affordable Care Act:

Rules and Regulations: Section 1301 Medicaid Affordable Care Coverage Groups

TABLE OF CONTENTS

Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1301 of the Medicaid Code of Administrative Rules entitled, "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 1301: "Coverage Groups" promulgated by the Executive Office of Health and Human Services and filed with the Rhode Island Secretary of State.

1301.

Medicaid Affordable Care Coverage Groups

1301.01 Scope and Purpose

The principal purpose of the federal Affordable Care Act of 2010 is to increase access to health care by leveraging resources, expanding choice, and removing the administrative, financial, and legal barriers that have prevented people from obtaining the coverage they need. Toward this end, the federal government has assisted the states in building state-of-the-art eligibility systems with the capacity to evaluate whether a consumer qualifies for affordable coverage funded in whole or in part through Medicaid, tax credits, and/or other subsidies. To ensure these eligibility systems function in the most efficient and consumer friendly manner possible, a single income standard – Modified Adjusted Gross Income or "MAGI" – must be used to determine the eligibility of all applicants for affordable coverage, including Medicaid. Accordingly, the federal government has eliminated distinctions in the financial criteria and standardized the eligibility requirements to the extent feasible for the Medicaid populations subject to the MAGI. This, in turn, made it possible for the states to reorganize the MAGI-eligible populations with similar characteristics into distinct, easily identifiable, Medicaid affordable care coverage (MACC) groups.

The purpose of this rule is to describe the Medicaid affordable care coverage groups. Any applicants for Medicaid in these groups will be subject to the MAGI standard and must apply using the eligibility system the State established in conjunction with implementation of the ACA. It is important to note that the provisions in federal (Title XIX and Title XXI of the U.S. Social Security Act) and State law (various chapters) that serve as the basis for the eligibility of members of the MACC groups has remained the same in most instances. Similarly, the State's authority to collect financial participation for the Medicaid coverage provided, whether under the Medicaid State Plan, Children's Health Insurance Program State Plan, or the Section 1115 demonstration waiver, also has not changed. However, for the sake of clarity, this rule will identify the appropriate legal bases and authorities for the populations included in each of the Medicaid affordable coverage groups described herein.

1301.02 Definitions.

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

"C**orrectional facility (jail and prison)"** means any place operated by the Rhode Island Department of Corrections designated as a place for the confinement of persons under sentence of imprisonment or persons committed for failure to pay a fine; a place for the confinement of persons duly committed to secure their attendance as witnesses in any criminal case; charged with a crime and committed for trial or examination; awaiting the availability of a court; duly committed for any contempt or upon civil process, convicted of any offense and sentenced to imprisonment therein; or pursuant to any other applicable provisions of law.

"**Foster Care Independence Act**" means the Act that amends Part "E" of Title IV of the Social Security Act to provide States with more funding and greater flexibility in carrying out programs designed to help children make the transition from foster care to self-sufficiency.

"**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).

"New Applicant" means an individual or family that 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-citizen**" means anyone who is not a U.S. citizen at the time of application including lawfully present immigrants and persons born in other countries who are present in the U.S. without documentation.

"**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.

"**Qualified non-citizen"** means a person lawfully present in the United States on the basis of immigration status who, if otherwise eligible for Medicaid, is prohibited or "barred" under federal law from receiving Medicaid coverage for a period of five (5) years from the date the immigration status was secured from the U.S. Immigration and Naturalization Service (INS). Certain qualified non-citizens are exempt from the ban, as specified in the Medicaid Code of Administrative Rules section 1305.

"Rhody Health Partners" means the Medicaid managed care delivery system for health coverage to eligible adults without dependent children, ages 19 to 64 (see section 1310 of the Medicaid Code of Administrative Rules), and adults with disabilities eligible under sections 0394 and 0395 of the Medicaid Code of Administrative Rules.

"**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 premium assistance program for individuals and families who have access to cost-effective commercial coverage (see section 1312 of the Medicaid Code of Administrative Rules).

"**Section 1115 Demonstration Waiver"** means the authorities granted by the federal government that gives the State the flexibility to expand eligibility to people who are not otherwise eligible,

provide new services that are typically not covered, and use innovative service delivery systems/approaches that improve care, increase efficiency, and reduce costs. Rhode Island currently operates nearly all facets of its Medicaid program under a Section 1115 waiver.

"Section 1931" means the Section of Title XIX of the Social Security Act that established the family category of coverage subsequent to the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) which severed the historical link between eligibility for cash assistance -- formerly called Aid to Families with Dependent Children (AFDC) -- and automatic Medicaid eligibility.

"Title XIX" means the section of the U. S. Social Security Act that established the Medicaid program and provides the legal basis for providing services and benefits to certain populations in each MACC group.

"Title XXI" means the section of the U. S. Social Security Act that established the Children's Health Insurance Program (CHIP) and provides the legal basis for providing services and benefits to certain targeted low income children and pregnant women through Medicaid.

"**Transitional or Extended Medicaid**" means the program that continues Medicaid coverage for up to twelve (12) months for MACC group families covered under Section 1931 when income exceeds the 110% of the FPL threshold.

1301.03 Types of Medicaid Affordable Care Coverage Groups
REV: March 2015

Federal law allows the states considerable flexibility to configure and administer their Medicaid and CHIP programs, including choosing which optional populations to cover, by what delivery system, and even whether to administer CHIP as a separate program, a Medicaid expansion or some combination of the two. As a result, every state's program is different; the way each organizes its Medicaid coverage groups is also somewhat unique.

Rhode Island's Medicaid affordable care coverage groups are comprised of individuals and families who share an eligibility characteristic, such as age or relationship. An applicant must meet the requirements to be included in one of the MACC groups to be eligible for Medicaid.

01. Description of MACC Groups – The Medicaid affordable care coverage groups are as follows:

(01) Families and Parents (caretaker relatives). The defining characteristic of this coverage group is a relationship with a child up to age 18, or 19 if enrolled in school full-time, who is eligible for Medicaid, as specified in section 1301.05 of the Medicaid Code of Administrative Rules (MCAR). Parent/caretaker eligibility is a function of how the eligible child is claimed for tax purposes as a dependent when constructing a MAGI household rather than where the child resides (See section 1307 of the Medicaid Code of Administrative Rules). The coverage group includes families with income up to 110% of the Federal Poverty Level (FPL) who are eligible under the Medicaid State Plan as well as parents/caretaker relatives with income from 110% to 133% of the FPL who are eligible under the State's Section 1115 demonstration waiver.

(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.

(05) Incarcerated Beneficiaries. Federal law and regulations prohibit the use of federal matching funds for health care provided on the premises of correctional facilities to otherwise Medicaid-eligible persons while incarcerated. Accordingly, full Medicaid health coverage of such persons is suspended during periods of incarceration. While the suspension remains in effect, the Medicaid agency is responsible for reimbursing costs related to acute care hospital stays of twenty-four (24) or more hours, but only when the otherwise Medicaid-eligible incarcerated person receives that care off the premises of the correctional facility.

- Reinstatement upon Release. Medicaid health coverage that has been suspended due to incarceration must be reinstated promptly by the Medicaid agency upon the person's release from a correctional facility.

- Residency. Suspension of Medicaid health coverage is limited to Rhode Island residents while incarcerated in correctional facilities. Medicaid health coverage for Rhode Islanders incarcerated in the correctional facilities of other states or in a federal penitentiary is terminated in accordance with the residency requirements set forth in MCAR 1305.11.

- Infants. An infant born to an incarcerated pregnant woman with suspended eligibility is qualified to receive Medicaid health coverage until the end of the month of the infant's first birthday in accordance with MCAR 1305.14.

02. MACC Group Eligibility Thresholds – The table below summarizes the MACC coverage groups and eligibility thresholds:

MAC Coverage Groups	*FPL Threshold*
Families and Parents/Caretakers	133%
Pregnant Women	253%
Children and Young Adults	261%
Adults 19-64 without children	133%

03. FPL Thresholds and MAGI Adjustments – The income levels for MACC groups identified in section 1301.03.01 above are eligibility thresholds that do not reflect adjustments made during the MAGI calculation. When applying the MAGI standard, income is reduced by about five (5) percentage points for household size to maximize eligibility. The FPL levels identified in this rule and other sections of the Medicaid Code of Administrative Rules applicable to MACC groups should be viewed by consumers accordingly.

1301.04 Medicaid Coverage Groups Excepted from the MAGI
REV: March 2015

There are currently multiple Medicaid coverage groups that are not subject to the MAGI. The income, resource, and non-financial criteria for populations within these coverage groups will remain the same. Relevant sections of the Medicaid Code of Administrative Rules are noted as appropriate.

Non-MAGI Coverage Groups
Anyone whose eligibility does not require an income determination by the Medicaid agency. Includes those eligible on the basis of : • Women eligible under the Breast and Cervical Cancer Treatment Act; • SSI (Medicaid Code of Administrative Rules section 0370); • Participation in a DCYF foster care, kinship or guardian program whether in a home-based, residential or institutional setting, including young adults aging out of foster care in Rhode Island (“Chafee youth”) (Medicaid Code of Administrative Rules sections 0342/1309); • Adoption assistance participants (Medicaid Code of Administrative Rules sections 0342/1309); • Infants born to Medicaid-covered women.
Anyone who is seeking eligibility for Medicaid coverage on the basis of age, disability, or blindness (Medicaid Code of Administrative Rules section 0352)

Non-MAGI Coverage Groups
Any person who is in need of Medicaid-funded long term services and supports (LTSS) in the home and community based setting or an institution. Includes: • Children seeking Medicaid coverage under the Katie Beckett provision (Medicaid Code of Administrative Rules section 0370.20) • Persons with developmental disabilities with a level of need requiring LTSS in a group home, shared living environment, at home, or an institute for persons with such disabilities. (Medicaid Code of Administrative Rules section 0398.10) • Adults and persons with disabilities with a level of need requiring LTSS in any approved setting (Medicaid Code of Administrative Rules section 0378)
Any person eligible as medically needy under the Medicaid State Plan
Adults over age 65 and adults with disabilities eligible for Medicare Premium Payment Program

1301.05 MACC and Non-MAGI Coverage Groups: Distinctions and Overlaps

Although the federal Affordable Care Act eliminated many of the distinctions between populations within coverage groups, certain differences remain within the MACC groups in Rhode Island that may affect eligibility and/or the scope of services.

01. Families: State Plan v. Section 115 Waiver Eligibility. The basis of eligibility for individuals and families in this coverage group differs. Families with income up to 110% of the FPL are eligible under the Medicaid State Plan through Section 1931 of Title XIX. Section 1931 parents and caretakers with income up to 133% of the FPL are eligible under the State's Section 1115 demonstration waiver.

    (01) Similarities -- The basis of eligibility – State Plan v. waiver – has no impact on the way eligibility is determined, the scope of coverage families receive or the way services are delivered. A family must have a Medicaid eligible child up to age 18, or 19 if in school, in the MAGI household to qualify under this MACC group. All eligible families receive services through the RIte Care delivery system (section 1309 of the Medicaid Code of Administrative Rules), unless access to affordable coverage requires enrollment in the RIte Share Premium Assistance Program (Medicaid Code of Administrative Rules section 1312).

    (02) Differences -- Families eligible under Section 1931 are treated differently than those eligible under the Section 1115 waiver when they reach the income threshold of 110% percent. The State must test any family covered under Section 1931 for an additional twelve months (12) of extended or transitional Medicaid (see Medicaid Code of Administrative Rules section 0342.50) when their income rises above the 110% FPL threshold. By contrast, when a family's income rises above the 133% Section 1115 waiver threshold, the transitional Medicaid option does not apply. Eligibility for parents/caretakers and children

is redetermined to assess whether they qualify under another Medicaid income threshold, or tax credits or subsidies for a plan available through the HealthSourceRI insurance marketplace. Details of the transitional/extended Medicaid program are as specified in Medicaid Code of Administrative Rules section 0342 until such time as the State receives further guidance from our federal partners on implementation through the ACA.

02. Pregnant Women: State-funded Group -- Pregnant women with income above the 253% FPL but below 350% of the FPL are State-funded only and, as such, are not part of the MACC group. However, members of this group are enrolled in RIte Care and qualify for the same MCO in-plan benefits as pregnant women eligible in the MACC group for pregnant women. Additional information on members of this coverage group is located in section 1309 of the Medicaid Code of Administrative Rules.

03. Newborns—Under the ACA, infants born to pregnant women covered under the MACC group for pregnant women on the date of delivery are automatically eligible for Medicaid (known as "deemed newborns"). Medicaid eligibility continues until the child's first birthday. (See section 1305.15 of the Medicaid Code of Administrative Rules).

04. Young Adult Former Foster Children -- The Medicaid eligibility of foster children is based on their participation in the programs administered by RI Department of Children, Youth and Families (DCYF). In Rhode Island, continuing Medicaid eligibility for youth aging out of foster care was provided through the federal Foster Care Independence Act of 1999 (Chafee Act). Distinctions in eligibility of these young adults were based on whether or not the services they received through DCYF were authorized and paid for under Title IV-E of the federal Social Security Act. Enactment of the ACA amended the Chafee Act to eliminate these distinctions and change Medicaid eligibility for youths aging out as follows, effective January 1, 2014:

(01) Basis for Eligibility. All young adults who were in DCYF foster care at the time they turned 18 years of age are eligible for continued Medicaid coverage, irrespective of whether they were receiving Title IV-E authorized services.

(02) Age. The age limit for coverage under the Chafee Act was raised from 21 to 26.

(03) Alternative Coverage. A provision was added to the Chafee Act specifying that young adults only qualify for Medicaid under this group if not otherwise eligible through SSI or as aged, blind or disabled and/or in need of long term services and supports.

(04) Residency. Young adults are now only eligible in the state where they resided at the time they aged out of foster care. Accordingly, to be eligible in Rhode Island, a young adult must be a current state resident and have been in foster care in Rhode Island at the time of aging out.

(05) Income. The eligibility of members of this population is not subject to a specific income threshold and, as a result, is exempt from the MAGI.

(06) Scope of Services. Young adults in this population must receive the same benefit package as Medicaid eligible children, including EPSDT up to age 21.

Although eligibility of young adults aging out of foster care was considerably altered by the ACA, members of this population are not included in a MACC group for income eligibility purposes.

05. Options for Adults 19-64 -- The MACC group for adults is distinct from the existing, non-MAGI Medicaid State Plan coverage group for adults who are aged, blind or disabled. There are individuals between the ages of 19 and 64 with chronic illnesses and disabling conditions who may be eligible under the MACC group on the basis of age and income. Adults seeking eligibility under the MACC group are not required to meet the disability criteria and assets set forth in the Medicaid Code of Administrative Rules sections 0351/0374, and must receive their determination within thirty (30) days rather than the ninety (90) days allowed for Non-MAGI coverage as blind or disabled, permitted under federal law. New applicants between the ages of 19 and 64 who apply using the new eligibility system must be evaluated on the basis of the MACC group income threshold for adults of 133% of the FPL first and then, if found ineligible under this group, must be referred to a Department of Human Services (DHS) agency representative for a full financial and clinical disability determination review.

1301.06 Covered Services

Members of all MACC groups are eligible for the full range of Medicaid benefits under the Medicaid State Plan and the State's Section 1115 waiver. A summary of covered services is as follows:

Doctor's office visits	Home health care
Immunizations	Skilled nursing care
Prescriptions	Nutrition services
Lab tests	Interpreter services
Mental health services	Childbirth education programs
Drug or alcohol treatment	Parenting classes
Referral to specialists	Smoking cessation programs
Hospital care	Transportation services
Emergency care	Dental care

NOTE: The services available to MACC group members varies by delivery system. See below for identification of delivery system and applicable Medicaid Code of Administrative Rules sections for full details on benefits.

1301.07 Delivery Systems

Eligible individuals and families receive coverage through a Medicaid managed care plan or their own commercial plan through the RIte Share Premium Assistance Program with fee-for-service wrap around coverage. Delivery systems for MACC groups are as follows:

MAC Coverage Groups	***Delivery System***
Families and Parents/Caretakers	RIte Care or RIte Share
Pregnant Women	RIte Care or RIte Share
Children and Young Adults	RIte Care or RIte Share
Adults 19-64 without children	Rhody Health Partners or RIte Share

The sections of the Medicaid Code of Administrative Rules pertaining to RIte Care (1309), RIte Share (1312) and Rhody Health Partners (1311) explain the organization of coverage through each of these programs. Enrollment provisions are located in the Medicaid Code of Administrative Rules section 1311.

1301.08 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).

1301. 09 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.