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TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 40 – MEDICAID FOR ELDERS AND ADULTS WITH DISABILITIES

SUBCHAPTER 10 – MANAGED CARE

Part 1 – Managed Care Service Delivery Arrangements

1.1 Overview of this Rule

A. The purpose of this rule is describe the managed care service delivery options for Elders and Adults with Disabilities and long-term care beneficiaries. The purpose is also to set forth in clear language the respective roles and responsibilities of the Executive Office of Health and Human Services (EOHHS), beneficiaries, health plans, and other contractual entities related to managed care enrollment and service delivery for Elders and Adults with Disabilities and long-term care beneficiaries.

Program	Rhody Health Partners	Medicare-Medicaid Plan	PACE
Population	Elders and Adults with Disabilities who do not have Medicare or other third-party coverage; Persons without Medicare who are receiving LTSS in the home or community-based service setting, are enrolled in RHP for essential primary care services only.	Elderly and non-elderly adults who have full Medicare (Parts A, B, and D) coverage and Medicaid Health Coverage	Medicaid beneficiaries age 55 and older who qualify for a nursing home level of care
Mandatory/ Voluntary Enrollment	Mandatory	Voluntary	Voluntary
Covered Services	Medicaid	Medicaid and Medicare Parts A, B, and D	Medicaid and Medicare Parts A, B,

Program	Rhody Health Partners	Medicare-Medicaid Plan	PACE
			and D (if eligible)
Participation Criteria	Age 21 and older; and Eligible for Medicaid Health Coverage on the basis of the SSI income standard (IHCC group)	Age 21 and older; Eligible for Medicaid Health Coverage on the basis of the SSI income standard (IHCC group) or the MAGI income standard (MACC group); and Enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D	Age 55 years and older; Meet criteria for high or highest need for a nursing facility level of care; and Meet all other requirements for LTSS

1.2 Definitions

A. For the purpose of this rule, the following terms are defined as follows:

1. “Appeal” means a request to review an “adverse benefit determination” based on medical necessity, appropriateness, health care setting, and effectiveness.

2. “Categorical eligibility” means an applicant/beneficiary included in an IHCC group who is eligible for Medicaid health coverage on the basis of income, resources, a characteristic, and/or a level of need in a mandatory or optional coverage group under the Medicaid State Plan, or who is treated as such, under the State’s Section 1115 demonstration waiver, in accordance with Title XIX. It excludes persons who must spenddown to become eligible for Medicaid health coverage as medically needy.

3. “Elders and adults with disabilities" or "EAD” means the Medicaid IHCC group established by R.I. Gen. Laws Chapter 40-8.5 for adults with an SSI characteristic related to age (elders 65 years of age or older) or disability.

4. “Executive Office of Health and Human Services" or "EOHHS” means the state agency that is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Title XIX Medicaid Program.

5. “Full dual eligible” means a beneficiary who is enrolled in Medicare Parts A and B and is eligible for Medicaid Health Coverage through an IHCC or MACC group for elders and adults with disabilities on the basis of income, resources and, when applicable, a characteristic or need for LTSS.

6. “Grievance” means an expression of dissatisfaction about any matter other than an action associated with an adverse benefit determination and includes complaints about the quality of care or services provided, and aspects of interpersonal relations such as rudeness of a provider or an employee or a failure to respect an enrollee’s rights.

7. “Integrated Health Care Coverage Group” or "IHCC" means any Medicaid coverage group consisting of adults who are eligible on the basis of receipt of Supplemental Security Income (SSI), SSI protected status, the SSI income methodology and a related characteristic (age or disability), or as a result of participation in another federal or State program (e.g., Breast and Cervical Cancer). Includes beneficiaries eligible for community Medicaid (non-long-term care), Medicaid-funded LTSS, and the Medicare Premium Payment Program (MPP).

8. “Integrated Care Initiative" or "ICI” means a Medicaid initiative that delivers integrated and coordinated services to certain Medicaid and Medicare enrolled (MME) beneficiaries through a managed care arrangement. The ICI includes services from across the care continuum including primary, subacute, and long-term care. The Medicare-Medicaid Plan (MMP) was established through ICI.

9. “Long-term services and supports" or "LTSS” means a spectrum of services covered by the Rhode Island Medicaid program that are required by individuals with functional impairments and/or chronic illness, and includes skilled or custodial nursing facility care, as well as various home and community-based services.

10. “Managed care arrangement" or "MCA” means a system that may use capitated financing to deliver high quality services and promote and optimize health outcomes through a medical home. Such an arrangement also includes services and supports that optimize the health and independence of beneficiaries who are determined to need or be at risk for Medicaid funded LTSS. An MCA includes any arrangement under which an MCO or contracted entity is granted some or all of the responsibility for providing and/or paying for long-term care services and supports through a contractual agreement with the Medicaid program.

11. “Managed care organization" or "MCO” means an entity that provides health plan(s) that integrate an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and emphasizes preventive and primary care.

12. “Medicaid Affordable Care Coverage Groups” or "MACC" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility as outlined in Part 30-00-1 of this Title.

13. “Medicaid and Medicare enrolled" or "MME” means full dual eligible or partial dual eligible plus beneficiaries who are receiving Medicaid health coverage, are enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D.

14. “Medicaid health coverage” means the full scope of health care services and supports authorized under the State’s Medicaid State Plan and/or Section 1115 demonstration waiver provided through an authorized Medicaid delivery system. The term encompasses the scope of health coverage available to categorically and medically needy eligible beneficiaries as well as those who are treated as such under the State’s Section 1115 demonstration waiver. However, the term does not apply to partial dual eligible persons who, under the provisions of this section, qualify only for financial assistance through the MPPP to help pay Medicare cost-sharing.

15. "Medically necessary service" means a medical, surgical, or other service required for the prevention, diagnosis, cure, or treatment of a health-related condition including any such services that are necessary to prevent or slow a decremental change in either medical or mental health status.

16. “Medically needy” means an IHCC group for elders and persons with disabilities who have high medical expenses and income that exceeds the maximum eligibility threshold for Medicaid. For non-LTSS beneficiaries in this coverage group, Medicaid eligibility and coverage occur when the amount they spend on medical expenses meets the medically needy income limit established by the State. For LTSS beneficiaries, excess income must be contributed toward the cost of care. Non-LTSS medically needy beneficiaries are covered on a fee-for-service basis.

17. “Medicare-Medicaid Plan" or "MMP” is an integrated managed care plan under contract with the federal Centers for Medicare and Medicaid

Services (CMS) and EOHHS to provide fully integrated Medicare and Medicaid benefits to eligible MME beneficiaries.

18. “Member" or "Enrollee” means a Medicaid-eligible person receiving benefits through Rhody Health Partners, a Medicare-Medicaid Plan, or the Program for All-Inclusive Care for the Elderly.

19. “Partial dual eligible” means a Medicare beneficiary who does not meet the requirements for Medicaid Health Coverage, but who is eligible for the State’s Medicare Premium Payment Program (MPP).

20. “Partial dual eligible plus” means a Medicare beneficiary who is eligible for Medicaid health coverage as medically needy and the MPP.

21. “Person-centered planning” means an individualized approach to planning that supports an individual to share his or her desires and goals, to consider different options for support, and to learn about the benefits and risks of each option. Person-centered planning places the individual at the center of decision-making. It is designed to enable people to direct their own services and supports to live a meaningful life that maximizes independence and community participation. Person-centered planning is a process that is directed by the individual, with impartial assistance and supported decision-making when helpful. Person-centered planning teams may include people who are close to the individual, as well as people who can help to bring about needed change for the person and access to appropriate services. However, at all times, the individual is empowered to decide who is part of the planning team. Person-centered planning must meet the requirements of 42 C.F.R. § 441.301(c)(1) including, but not limited to, ensuring that a person has sufficient and necessary information in a form he or she can understand to make informed choices, enabling the person to direct the process to the maximum extent possible, and conducting planning meetings at times and in locations that are convenient to the individual.

22. “Primary care” means an array of primary, acute, and specialty services provided by licensed health professionals that includes, but is not limited to: health promotion, disease prevention, health maintenance, counseling, patient education, various specialty services and diagnosis and treatment of acute and chronic medical and behavioral health illnesses and conditions in a variety of health care settings (e.g., office, inpatient, care, home care, day care).

23. “Program of All Inclusive Care for the Elderly" or "PACE” means a risk-based managed care service delivery option for beneficiaries who have

Medicare and/or Medicaid coverage and meet the financial and clinical criteria for a nursing facility level of long-term services and supports. Beneficiaries must be 55 years or older to participate in this option.

24. "Rhody Health Options" or "RHO" means the capitated managed care delivery system operating under contract with EOHHS to manage and coordinate Medicaid covered services and supports, including LTSS, for eligible MNM and MME beneficiaries and to coordinate Medicaid covered services with Medicare covered services for eligible MME beneficiaries. RHO terminates as service delivery option on September 30, 2018.

25. "Rhody Health Partners" or "RHP" means the Medicaid managed care service delivery option for adults in the IHCC groups that provides primary/acute and specialty care through a medical home that focuses on prevention and promoting healthy outcomes. The rules for RHP for adults ages 19-64 in the MACC groups are located in Part 30-05-2 of this Title.

26. "SSI income standard" means the basis for determining Medicaid eligibility that uses the definitions and calculations for evaluating income and resources established by the U.S. Social Security Administration for the Supplemental Security Income (SSI) program.

27. "SSI protected status" means the class of beneficiaries who retain categorical eligibility for Medicaid even though they are no longer eligible for SSI due to certain changes in income or resources.

1.3 Rhody Health Partners (RHP)

1.3.1 Authority and Scope

A. In 2005, R.I. Gen. Laws § 40-8.5-1.1 authorized the Medicaid agency to establish mandatory managed care delivery systems for adults nineteen (19) years of age or older who are eligible on the basis of participation in the Supplemental Security Income (SSI) program (see § 00-1.5 of this Chapter) or an SSI-related characteristic associated with age or a disability and income. In Rhode Island, persons with SSI-related characteristics are eligible under the Medicaid State Plan option for low-income elders and adults living with disabilities (EAD) in accordance with R.I. Gen. Laws Chapter 40-8.5. The requirements for adults in associated special eligibility groups that have unique financial (e.g., SSI Protected Status) or clinical criteria (e.g., breast and cervical cancer coverage group) or limited benefits (e.g., partial dual eligible group and the Medicare Premium Payment Program) are also located in § 05-1.6 of this Chapter.

B. Beneficiaries eligible in these coverage groups who do not require LTSS are sometimes referred to as “Community Medicaid” and are members of the State’s Integrated Health Care Coverage (IHCC) groups. The provisions governing eligibility set forth in Subchapter 05 Part 1 of this Chapter and § 00-3.1.2 of this Chapter and enrollment as established herein will remain in effect unless or until replaced.

C. IHCC group beneficiaries who are eligible on the basis of SSI income standard, do not require LTSS, and do not have third-party coverage are subject to mandatory enrollment in a Rhody Health Partners (RHP) Medicaid managed care plan. Eligible beneficiaries have the choice of two-RHP participating health plans.

1.3.2 EOHHS Responsibilities

A. EOHHS, or its designee, is responsible for determining the eligibility of members in the IHCC groups in accordance with requirements established in the applicable sections of federal and State laws, rules and regulations unless deemed eligible by virtue of receipt of SSI. In general, persons will be informed of their enrollment options at the time a determination of eligibility is made.

B. IHCC group beneficiaries who are eligible on the basis of SSI income standard, do not require LTSS, and do not have third-party coverage are subject to mandatory enrollment in an RHP Medicaid managed care plan. EOHHS enters into contractual arrangements with the MCOs offering RHP plans that assure access to high quality Medicaid covered services and supports. EOHHS is also responsible for informing beneficiaries of their service delivery options and initiating enrollment in a participating RHP plan.

1.3.3 RHP Enrollees

A. Enrollment in an RHP plan typically occurs no more than thirty (30) days from the date of the determination of eligibility unless excluded from enrollment.

B. Excluded from RHP enrollment. Beneficiaries in the following categories are excluded from enrollment in an RHP plan and may be enrolled in an alternative Medicaid managed care arrangement:

1. Third-Party Coverage – SSI and EAD eligible beneficiaries who are enrolled in Medicare Parts A and/or B or have other third-party coverage are not subject to mandatory enrollment in an RHP plan.

2. Exempt Due to Age – SSI and EAD beneficiaries who are between the ages of nineteen (19) and twenty-one (21) are exempt from mandatory enrollment in RHP and receive all Medicaid health coverage on a fee-for-service basis.

3. Medically Needy Eligible, Non-LTSS – Beneficiaries who are determined eligible as medically needy due to excess income and resources are also exempt from enrollment in managed care. Medicaid health coverage for beneficiaries in this category is provided in accordance with the provisions of Subchapter 05 Part 2 of this Chapter.

4. The excluded populations receive all Medicaid covered services on a fee-for-service basis, unless they are otherwise eligible for another Medicaid delivery system. In addition, during the period while awaiting plan enrollment, beneficiaries eligible for RHP receive health coverage on a fee-for-service basis.

1.3.4 RHP Enrollment Process

A. RHP-eligible beneficiaries have the choice of two participating plans. EOHHS employs a formula, or algorithm, to assign prospective enrollees to a health plan. Eligible beneficiaries are sent a letter from EOHHS at least forty-five (45) days prior to the enrollment effective date notifying them of their health plan assignment and the enrollment effective date. The letter also includes information on their health plan choices. Beneficiaries are given at least thirty (30) days to review the health plan enrollment assignment and request a change. At the end of this timeframe, EOHHS enrolls the beneficiary, effective the first day of the following month, as follows:

1. Beneficiary Action – If the beneficiary makes a choice to change health plan assignment, EOHHS initiates enrollment, as appropriate, into the selected RHP plan.

2. No Beneficiary Action – If a beneficiary does not respond within the allotted timeframe, the beneficiary is enrolled in the assigned RHP plan.

3. Delivery System Changes –Enrollment into RHP is always prospective in nature. Medicaid beneficiaries are required to remain enrolled in this service delivery option, but they can request reassignment to another plan within the first ninety (90) days of enrollment. They are also authorized to transfer from one MCO to another once a year during an open enrollment period. 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 Subchapter 00 Part 2 of this Chapter 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, as described in Part 10-05-2 of this Title. If a beneficiary becomes eligible for LTSS and:

a. Does not have Medicare, essential primary care services through RHP are continued if the LTSS is provided in a home or community-based setting; in such cases, all LTSS is provided on a fee-for-service basis. If LTSS is provided in a health institution such as a nursing facility, EOHHS initiates RHP disenrollment and all Medicaid covered services, including essential primary care services and LTSS are provided fee-for-service;

b. Is eligible for or enrolled in Medicare, EOHHS initiates RHP disenrollment and, if eligible, offers the alternative option of enrolling in Medicaid LTSS managed care arrangements such as the Program for All-Inclusive Care for the Elderly (PACE), a Medicare-Medicaid Plan, or a fee-for-service (FFS) alternative.

4. Auto Re-Assignment after Resumption of Eligibility – Medicaid beneficiaries who are disenrolled from RHP due to a loss of eligibility and who regain eligibility within sixty (60) calendar days are automatically re-enrolled, or assigned, back into the managed care service delivery option they were in previously if they do not make a plan selection. If more than sixty (60) calendar days have elapsed, the enrollment process will follow the process established in this section.

1.3.5 RHP Member Disenrollment

A. Disenrollment from an RHP plan may be initiated by EOHHS or the plan in a limited number of circumstances as follows:

1. EOHHS Initiated Disenrollment – Reasons for EOHHS-initiated disenrollment from an RHP plan include but are not limited to:

a. Death;

b. No longer Medicaid eligible;

c. Eligibility error;

d. Enrolled in Medicare or other third-party coverage;

e. Placement in a long-term care institution – such as a nursing facility – for more than thirty (30) consecutive days;

f. Placement in Eleanor Slater, Tavares, or an out-of-state hospital;

g. Incarceration; or

h. Eligibility for Medicaid LTSS in a facility.

2. Member Disenrollment Requested by RHP plan – An RHP plan may request in writing the disenrollment of a member whose continued enrollment seriously impairs the plan's ability to furnish services to either the particular member or to other members. An RHP plan is not permitted to request disenrollment of a member due to:

   a. An adverse change in the member's health status;

   b. The member's utilization of medical services; or

   c. Uncooperative behavior resulting from the member's special needs.

3. All plan-initiated disenrollments are subject to approval by EOHHS, after an administrative review of the facts of the case has taken place. Beneficiaries have the right to appeal EOHHS' disenrollment decision (see Part 10-05-2 this Title). EOHHS will determine the disenrollment date as appropriate, based on the results of this review.

1.3.6 Grievances, Appeals and Hearings

A. Federal law requires that Medicaid MCOs have a system in place for enrollees that includes a grievance process, an appeal process, and access to an administrative fair hearing through the State Administrative Fair Hearing Process. For in-plan services, RHP members must exhaust the internal MCO Level I and Level II appeals process before requesting an EOHHS hearing. Regulations governing the appeals process for out-of-plan services are found in Part 10-05-2 of this Title.

1. Types of Internal Appeals – The plan must maintain internal policies and procedures to conform to state reporting policies and implement a process for logging appeals. Appeals filed with a managed care plan fall into three (3) categories:

   a. Medical Emergency. An MCO must decide the appeal within seventy-two (72) hours when a treating provider, such as a doctor who takes care of the member, determines the care to be an emergency and all necessary information has been received by the MCO.

   b. Non-Emergency Medical Care. The two levels of a non-emergency medical care appeal are as follows:

      (1) For the initial level of appeal, the MCO must decide the appeal within fifteen (15) days from the date that all necessary information is dated as received by the MCO. If

the initial decision is adverse to the member, then the MCO must offer the second level of appeal.

(2) For the second level of appeal, the MCO must make a decision within fifteen (15) days of the date that all necessary information is dated as received by the MCO.

c. Non-Medical Care. If the appeal involves a problem other than medical care, the MCO must resolve the appeal within thirty (30) days of the date that all necessary information is dated as received by the MCO.

2. External Appeal. RHP members who exhaust the health plan's internal appeal processes may choose to initiate an "external appeal," in accordance with the Rhode Island Department of Health's Rules and Regulations for the Utilization Review of Health Care Services (216-RICR-40-10-20). A member does not have to exhaust the third level appeal before accessing an EOHHS hearing.

3. Regulations governing the appeals process are found in Part 10-05-2 of this Title.

1.4 RHP Benefit Package

A. The IHCC groups participating in RHP under this section receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver. Covered services may be provided through the managed care plan or through the fee-for-service delivery system if the service is "out-of-plan" – that is, not included in the managed care plan but covered under Medicaid. Fee-for-service benefits may be furnished either by the managed care provider or by any participating provider.

1. Access to Benefits – Each RHP member selects a primary care provider (PCP) who performs necessary medical care and coordinates referrals to specialty care. The PCP orders treatment determined to be medically necessary in accordance with the health plan's policies. Prior authorization rules may apply, as required by the Medicaid agency.

2. Delivery of Benefits – In-plan services are paid for on a capitated basis.

3. Medical Necessity – The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered service is required and appropriate. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

4. Medicaid Benefits – The coverage provided through RHP is categorized as follows:

RHP Benefits	
(a) In-Plan	**(b) Out-of-Plan**
Inpatient Hospital Care	Dental Services
Outpatient Hospital Services	Court-ordered Mental Health and Substance Abuse Services Ordered to a Non-Network Facility or Provider
Physician Services	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS' non-emergency transportation broker.)
Family Planning Services	Nursing home Services in Excess of 30 Consecutive Days
Prescription Drugs	Residential Services for Beneficiaries with Intellectual and Developmental Disabilities
Non-Prescription Drugs	
Laboratory Services	Center of Excellence for Opioids
Radiology Services	Peer Recovery Specialist
Diagnostic Services	Recovery Navigation Program (RNP) Long-term care services and supports after 30 days
Outpatient & Inpatient Mental Health and Substance Use Services	
Court-ordered Mental	

RHP Benefits	
(a) In-Plan	**(b) Out-of-Plan**
Health and Substance Abuse Services – Criminal Court	
Court-ordered Mental Health and Substance Abuse Treatment – Civil Court	
Home Health Services	
Emergency Room Service and Emergency Transportation Services	
Nursing Home Care and Skilled Nursing Facility Care for the first 30 days	
Services of Other Practitioners	
Podiatry Services	
Optometry Services	
Oral Health	
Hospice Services	
Durable Medical Equipment	
Group/Education Programs	

RHP Benefits	
(a) In-Plan	**(b) Out-of-Plan**
Interpreter Services	
Transplant Services	
Adult Day Services	
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS and those at High Risk for Acquiring HIV	
AIDS Medical Case Management	
Opioid Treatment Provider Health Home	
Preventive services, including: Homemaker Minor Environmental Modifications Physical Therapy Evaluation and Services	

1.5 Integrated Care Initiative (ICI)

1.5.1 Authority and Overview

A. In accordance with R.I. Gen. Laws Chapter 40-8.13, the State's Section 1115 Waiver Demonstration, and other federal waivers and authorities, EOHHS has developed and implemented the ICI to expand access to comprehensive care

management and services through a managed care delivery system known as the Medicare-Medicaid Plan (MMP).

B. Under the authority of a special federal Financial Alignment Demonstration, the MMP integrates and coordinates Medicare and Medicaid covered services through a managed care arrangement for MME beneficiaries. Enrollment is voluntary for eligible beneficiaries. The operations of the MMP are bound by a three-way agreement between EOHHS, the federal Centers for Medicare and Medicaid Services (CMS), and the participating MCO.

1.5.2 EOHHS Responsibilities

A. As the single State agency for Medicaid, EOHHS oversees administration of the program and is responsible for ensuring that eligibility determinations and enrollment procedures are conducted in accordance with applicable federal and State laws and regulations. To enroll in the MMP, applicants must qualify as an MME in accordance with the applicable provisions set forth herein. Enrollment in PACE is a standing option for eligible beneficiaries. Applicants are processed as summarized below:

1. Eligibility Determinations – EOHHS or its designee is responsible for determining the eligibility of applicants for Medicaid and Medicaid-funded LTSS, including those who have third party coverage through Medicare. All LTSS applicants must meet financial and clinical criteria related to the need for an institutional level of care set forth in Part 50-00-5 of this Title and Part 50-00-6 of this Title. The eligibility duties of EOHHS also include:

    a. Level of Need. EOHHS applies clinical criteria to determine whether and to what extent the needs of an applicant/beneficiary require the level of care provided in an institutional setting – nursing facility, hospital, intermediate care facility for intellectual disabilities. EOHHS is also responsible for identifying beneficiaries for whom there is unlikely to be an improvement in functional/medical status.

    b. Beneficiary Liability. EOHHS determines the amount LTSS beneficiaries must pay toward the cost of the care – beneficiary liability – through a process referred to as the post-eligibility treatment of income (PETI). All beneficiaries of Medicaid-funded LTSS are required under the Medicaid State Plan and the State's Section 1115 Waiver to contribute to the cost of the services they receive to the full extent their income and resources allow, irrespective of care setting or service delivery option. Failure to make such payments may result in termination of eligibility for non-cooperation (See Part 50-00-8 of this Title).

c. Person Centered Planning and Service Arrangements. In addition to determining eligibility and beneficiary liability for Medicaid LTSS, EOHHS is responsible for engaging beneficiaries in person-centered care planning in which the beneficiary leads an assessment and discussion of his or her needs and goals and information about various care options. This process includes the development of a service plan that corresponds to the beneficiary's needs and goals and assists beneficiaries and their families in selecting the appropriate service delivery option and making care arrangements. EOHHS will postpone in - person person centered planning that is scheduled to occur during the novel Coronavirus Disease (COVID-19) declaration of emergency for sixty (60) days or until the termination of the novel coronavirus declaration of emergency, whichever is longer.

2. Service Delivery Options and Enrollment – EOHHS assures that every beneficiary has access to health coverage through the service delivery options provided for in federal and State law that most appropriately meet his or her needs. Once a determination of eligibility has been made, beneficiaries are evaluated for enrollment in managed care versus fee-for service.

1.5.3 Service Delivery Options

A. EOHHS provides the following delivery options to Medicaid beneficiaries who meet program participation criteria:

1. Medicare-Medicaid Plan (MMP) – The MMP is a managed care service delivery system designed to manage and coordinate the full spectrum of both Medicaid and Medicare services for Medicare and Medicaid (MME) adults. See § 1.7 of this Part for more information on the MMP.

2. PACE – PACE is a service delivery option for beneficiaries who have Medicare and/or Medicaid coverage and meet a "high" or "highest" level of need for LTSS in accordance with Part 50-00-5 of this Title. Beneficiaries must be 55 years old or older to participate in this option. See § 1.13 of this Part for more information on PACE.

3. Fee-for-service – Beneficiaries participating in the MMP receive at least some of their Medicaid health coverage on a fee-for-service basis. Beneficiaries eligible for the MMP, and PACE also have the option to obtain all of their Medicaid covered services on a fee-for-service basis.

4. Care Management Entity provide care coordination and assistance to beneficiaries in Medicaid fee-for-service who are not eligible for enrollment in managed care. The Care Management Entity provides beneficiaries assistance with:

   a. Navigating the health care system

   b. Care management, client advocacy, and health education

   c. Working with a person's primary care provider and

   d. Provides links to community resources.

5. Participation in Care Management is voluntary. The State targets eligible beneficiaries for care management based upon clinical need and functional status.

1.6 Rhody Health Options (RHO)

A. In accordance with Section 7 of Pub. Laws 18-047 enacted on June 22, 2018, Medicaid beneficiaries enrolled in RHO on and before October 1, 2018 will be placed in fee-for-service arrangements effective that date for all Medicaid covered long-term services and supports. The RHO program termination date is September 30, 2018.

B. Medicaid beneficiaries who were enrolled in RHO on and before October 1, 2018 will continue to receive all medically necessary services as contained in § 1.4(A)(4) of this Part. The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered service is required and appropriate. Prior to the termination date of RHO for existing beneficiaries and after for all new beneficiaries, any member who is dually eligible for Medicaid and Medicare may be enrolled in a MMP while retaining the choice to opt out and receive LTSS on a fee-for service basis. For Medicaid beneficiaries who do not have Medicare, the transition is as follows:

   1. Medicaid-only LTSS in a home and community-based setting --Beneficiaries who are seeking or receiving LTSS in a home and community-based setting as defined in Part 50-10-1 of this Title will receive all essential primary care benefits through a Rhody Health Partners managed care plan. Medicaid LTSS will be provided out-of-plan and paid for on a fee-for-service basis after the first 30 days.

   2. Medicaid-only LTSS in a health institution --Persons seeking or receiving Medicaid in an institutional setting such as a nursing facility or hospital in accordance with Part 50-05-1 of this Title will be receive all Medicaid-

covered services (primary care, subacute care, long-term services and supports) on a fee-for-service basis.

1.6.1 RHO Appeals

The class of Medicaid beneficiaries who were enrolled in RHO on and before October 1, 2018 do not have the right to appeal the termination of their RHO coverage in accordance with 42 C.F.R. § 431.220 (b) and § 10-05-2.2.1(A)(7)(a) of this Title. The right to appeal agency actions unrelated to this change in law and policy that affect eligibility, or the scope, amount, and or duration of Medicaid benefits is preserved.

1.7 Medicare-Medicaid Plan (MMP)

1.7.1 Overview

Under the authority of a special federal Financial Alignment Demonstration, the MMP is designed to manage and coordinate the full spectrum of both Medicaid and Medicare services for Medicare and Medicaid (MME) adults. Enrollment is voluntary for eligible beneficiaries. A three-way agreement between EOHHS, the MCO operating the MMP, and the federal Centers for Medicare and Medicaid Services (CMS) governs the organization, financing, and delivery of Medicaid and Medicare services to MME beneficiaries who choose to participate.

1.7.2 MMP Participation Criteria

A. MME beneficiaries are eligible for participation in the MMP if they are age twenty-one (21) and older as follows:

1. MME Enrollees – Medicare-Medicaid beneficiaries who are receiving Medicaid health coverage, enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D. This cohort includes MME and other Community Medicaid IHCC group beneficiaries as well as those who need LTSS. Eligible MME beneficiaries include:

    a. Members of the IHCC groups receiving Community Medicaid, including persons with serious and persistent mental illness, who do not need LTSS;

    b. MAGI-eligible adults in the MACC group for parents/caretakers;

    c. LTSS recipients residing in institutional or home and community-based settings including those qualifying for the level of care provided in a nursing facility and intermediate care facility for persons with intellectual disabilities (ICF-ID) – such as nursing

facility, assisted living and ID group home residents as well as those residing in their own homes; and

d. Persons with End Stage Renal Disease (ESRD) at the time of enrollment.

2. MME beneficiaries are entitled to Medicaid State Plan and Section 1115 waiver services that are not covered by Medicare.

3. Excluded Beneficiaries – Certain Medicaid beneficiaries are excluded from participating in the MMP as indicated below:

a. Beneficiaries excluded from the MMP.

b. Medicare beneficiaries who are not eligible for Medicaid health coverage, including partial dual eligible beneficiaries who participate in the Medicaid Premium Payment Program (MPP) as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Beneficiaries (SLMBs), and Qualifying Individuals (QIs).

c. Dual Eligible beneficiaries who are not qualified to enroll in all segments of Medicare.

d. Medicaid beneficiaries residing in Tavares, Eleanor Slater, or out-of-state hospitals.

e. Beneficiaries who are in hospice on the effective enrollment date. Enrollees who elect hospice care after they are enrolled in the MMP can remain in the MMP.

f. Beneficiaries who reside out-of-state for six (6) consecutive months or longer.

g. Beneficiaries who are eligible for the Medicaid Buy-In Program for Working People with Disabilities (known as the “The Sherlock Plan” in Rhode Island).

h. Dual eligible beneficiaries who are between the ages of nineteen (19) and twenty (20) are exempt from enrollment in managed care and receive all Medicaid health coverage on a fee-for-service basis.

i. Beneficiaries who are determined eligible as medically needy for Community Medicaid due to excess income and resources are exempt from enrollment in managed care.

1.7.3 MMP Service Delivery Option

MMP participating beneficiaries receive services through a managed care arrangement operating under contract with EOHHS and CMS. MMP enrollees receive services through a health plan offered by an MCO. The operations of the MMP are bound by a three-way agreement with EOHHS and CMS to integrate the full range of Medicare and Medicaid services (primary care, acute care, specialty care, behavioral health care, and LTSS) in accordance with a rate structure that includes federal and state funding streams for all MME adults. Accordingly, the MMP must provide accessible, high-quality services and supports focused on optimizing the health and independence of one of the most fragile Medicaid populations. Enrollment in the MMP is voluntary.

1.7.4 MMP Enrollment

A. The MMP offers MME beneficiaries the opportunity to obtain comprehensive integrated services through a single health plan.

1. Passive or Auto-Enrollment – Eligible beneficiaries may be passively enrolled by EOHHS, or auto-enrolled, in the MMP unless they are excluded from passive enrollment on the basis of one of the following criteria:

    a. The MME beneficiary is enrolled in a Medicare Advantage plan that is not operated by the same MCO as the MMP;

    b. The beneficiary has been auto-enrolled by CMS into a Medicare Part D plan in the same calendar year that the MME would qualify for the MMP;

    c. The MME is currently enrolled in comprehensive health insurance coverage through a private commercial plan or group health plan provided through an employer, union, or TRICARE; or

    d. The beneficiary has affirmatively opted-out of passive enrollment into an MMP or a Medicare Part D plan.

2. Opt-in Enrollment –Eligible beneficiaries may be offered the option to opt into the MMP. MME beneficiaries who are not eligible for passive enrollment will be offered the opportunity to opt-in to an MMP by completing an application in writing or via phone. Individuals enrolled in PACE may elect to enroll and participate in the MMP if they choose to disenroll from PACE.

1.7.5 Enrollment Information

A. EOHHS is responsible for ensuring that all MME beneficiaries who meet the criteria to participate in the MMP have access to the information necessary to make a reasoned choice about their coverage options. As indicated in § 1.2(A)(25) of this Part, the person-centered planning process plays a critical role in ensuring that beneficiaries are aware of the full range of service delivery options available to them based on their level of need and personal goals. Accordingly, prospective participants are sent a written communication informing them of the option to enroll in an MMP, as well as information on the availability of independent enrollment options counseling and other supports to help beneficiaries make informed enrollment decisions. Eligible individuals who opt-out of or do not enroll in an MMP have the option to enroll in PACE if eligible, or receive all Medicaid covered services – including LTSS – on a fee-for-service basis, unless they are otherwise eligible for another Medicaid delivery system.

B. Communications with MME beneficiaries who qualify to participate in the MMP includes information about each of the following:

1. Enrollment Opt-In and Opt-Out Process – Participation in an MMP is voluntary. MME beneficiaries eligible for passive enrollment are informed that they may choose to opt out of enrollment in the MMP and are provided with instructions on how to proceed. MME beneficiaries eligible for passive enrollment who opt-out may choose any of the alternative service delivery options for which they may qualify. Eligible beneficiaries who are not passively enrolled are provided with instructions on how to enroll in an MMP.

2. Decision Timeframe – Eligible beneficiaries may enroll in an operational MMP at any time up until six (6) months prior to the end of the federal demonstration under which the MMP was implemented. The federal demonstration is scheduled to end on December 31, 2020. Information is provided about enrollment decision time-frames as follows:

    a. Passive Enrollment. Beneficiaries eligible for passive enrollment into the MMP are sent a first notification that they will be passively enrolled between sixty (60) and ninety (90) days prior to the effective date of enrollment; a second reminder notification is sent to the beneficiary at least thirty (30) days prior to the effective date of enrollment. If the beneficiary makes an enrollment choice within the specified timeframe, EOHHS initiates enrollment accordingly. If a beneficiary does not respond within the specified timeframe, enrollment in the MMP proceeds in accordance with the terms specified in the initial communication from EOHHS.

b. Opt-in Enrollment. MME beneficiaries who are eligible for the MMP but are not passively enrolled may be sent a notification that they have the option to enroll in an MMP. Opt-in enrollment requests received through the 10th day of the month will take effect on the first day of the following calendar month. Opt-in enrollment requests received on the 11th day of the month or later will take effect on the first day of the second month after the request was submitted. Beneficiaries do not need to make an enrollment decision to opt into the MMP within a specified timeframe after receiving notice from EOHHS informing them that they are eligible to enroll in the MMP. However, no new enrollments will be accepted during the six (6) months prior to the end date for the federal demonstration under which the MMP was implemented. The federal demonstration is scheduled to end on December 31, 2020.

3. Opportunity to Change – Beneficiaries who are being passively enrolled or who opt-in to an MMP may cancel their enrollment any time prior to their effective enrollment date. Once enrolled, beneficiaries may change service delivery options on a monthly basis at any time, but enrollment in the MMP will continue through the end of the month. The requested change will be effective on the first day of the following month. Beneficiaries who cancel enrollment into or voluntarily disenroll from an MMP will be enrolled in fee-for-service (FFS), effective the first day of the following month. Beneficiaries who voluntarily disenroll from the MMP plan can choose to re-enroll in the plan on a monthly basis if they continue to be eligible for enrollment in the MMP, but they will not be passively enrolled in the MMP. Beneficiaries may also be eligible for enrollment in PACE (see § 1.13 of this Part).

4. Auto Re-Assignment after Resumption of Eligibility – MME beneficiaries who are disenrolled from an MMP due to a loss of eligibility are eligible for re-enrollment in the plan if eligibility is reinstated and they otherwise meet the requirements for enrollment. Beneficiaries eligible for re-enrollment will be passively enrolled if they meet the requirements for passive enrollment. Otherwise, they will be offered opt-in enrollment.

1.7.6 MMP Member Disenrollment

A. EOHHS Initiated Disenrollment – Reasons for EOHHS disenrollment from an MMP include but are not limited to:

1. Death;

2. No longer eligible for Medicaid;

3. Loss of Medicare Part A and/or Part B;

4. Enrollment into a Medicare Advantage (Part C) plan or Medicare Part D prescription drug plan;

5. Eligibility error;

6. Placement in Eleanor Slater Hospital, Tavares, or out-of-state residential hospital;

7. Incarceration;

8. Changed state of residence;

9. Enrollment in PACE; and

10. Opt-out to fee-for-service.

B. Beneficiaries who are involuntarily disenrolled because of incarceration are provided Medicaid coverage on a fee-for-service basis. Beneficiaries who are involuntarily disenrolled for any other reason and remain eligible for Medicaid coverage are enrolled in FFS.

C. Medicare-Medicaid Plan Disenrollment Request – The Medicare-Medicaid plan may make a written request to EOHHS and CMS asking that a particular member be disenrolled. Any such request is only considered by EOHHS and CMS when made on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members, the member knowingly provided fraudulent information on the MMP enrollment form that materially affected his or her eligibility to enroll in the MMP, or the member intentionally permitted others to use his or her member identification card to obtain services under the MMP. EOHHS and CMS do not permit disenrollment requests based on:

1. An adverse change in the member's health status;

2. The member's utilization of medical services;

3. Uncooperative or disruptive behavior resulting from the member's special needs;

4. The member exercising treatment decisions with which the MCO or the MCO's provider(s) disagree; or

5. Diminished or diminishing mental capacity of the member.

D. Beneficiaries who are involuntarily disenrolled based on a written request by the MMP receive their Medicaid benefits on a fee-for-service basis.

E. Disenrollment Review – All disenrollments are subject to approval by EOHHS and CMS. Beneficiaries have the right to appeal EOHHS' and CMS' disenrollment decision (see Part 10-05-2 of this Title). EOHHS and CMS determine jointly the disenrollment date as appropriate.

1.7.7 Grievances, Appeals and Hearings

A. MMP members have multiple avenues for contesting decisions that affect their health coverage, including EOHHS and CMS administrative fair hearings. The process is as follows:

1. MMP Grievances – Grievances directed toward the MMP may be internal or external.

   a. Internal or plan level grievances. MMP members, or their authorized representatives, can file a grievance with the MCO or a participating provider at any time by calling or writing the MCO or the provider. The MCO must require providers to forward grievances to the MCO. If the MMP member is requesting remedial action related to a Medicare issue, the member must file the grievance with the MCO or the provider no later than sixty (60) days after the event or incident triggering the incident (see Part 10-05-2 of this Title). The MCO must respond, orally or in writing, to an internal grievance within thirty (30) days after the MCO receives the grievance. The MCO must respond, orally or in writing, within twenty-four (24) hours whenever the MCO extends the timeframe for a decision or refuses to grant a request for an expedited grievance.

   b. External. MMP members, or their authorized representatives, can file a grievance by contacting 1-800-MEDICARE or EOHHS. Any grievance filed with EOHHS will be reviewed by a joint EOHHS-CMS contract oversight team and be made available to the MCO.

2. MMP Appeals – The process for handling appeals varies depending on whether the beneficiary is disputing an action related to Medicaid or Medicare coverage. For services covered under Medicare Part D, MMP members must follow the appeals process established by CMS in Subparts M and U of 42 C.F.R. Part 423. For services covered by Medicare Part A, Medicare Part B, and/or Medicaid in-plan services, MMP members must complete one level of internal appeal before requesting an

external review. Regulations governing the appeals process for Medicaid out-of-plan services are found in Part 10-05-2 of this Title. The process for filing subsequent appeals after the first level internal appeal is as follows:

a. Services covered by Medicare Part A and/or B. Subsequent appeals after the first level internal appeal for traditional Medicare A and B services that are not fully in favor of the enrollee will be automatically forwarded to the Medicare Independent Review Entity (IRE) by the MMP.

b. Services covered by Medicaid only. Subsequent appeals for services covered by Medicaid only (including, but not limited to, LTSS and behavioral health) may be made to the EOHHS Hearing Office and/or to the Rhode Island External Review Entity per State regulations (Part 10-05-2 of this Title) after the first plan-level Appeal has been completed. If an appeal is filed with both the Rhode Island External Review Entity and the EOHHS Hearing Office, the MCO will be bound by any determination in favor of the member that is closest to the relief requested by the member. Appeals related to drugs excluded from Medicare Part D that are covered by Medicaid must be filed with the MMP in accordance with Part 10-05-2 of this Title, and Subchapter 00 Part 2 of this Chapter, and the requirements contained herein.

c. Services covered by both Medicare and Medicaid. After the first level internal appeal, appeals for services for which Medicare and Medicaid overlap (including, but not limited to, home health, durable medical equipment, and skilled therapies, but excluding Part D) will be auto-forwarded to the IRE by the MMP.

d. After the first plan-level appeal for Medicare and Medicaid overlapping services, a member may file a request for a hearing with the EOHHS State Fair Hearing Office. After the first plan-level appeal for Medicare and Medicaid overlap services, a member may also file a request for a hearing with the Rhode Island External Review Entity per State regulations (Part 10-05-2 of this Title). If an appeal is filed with both the IRE and either the Rhode Island External Review Entity or the EOHHS Hearing Office, the MCO will be bound by any determination in favor of the member that is closest to the relief requested by the member.

3. Internal appeals timeframes

a. First Level. An MMP member must file a first-level internal appeal with the plan within sixty (60) calendar days following the date of the notice of adverse action that generates the appeal.

b. Standard appeals. For first-level internal appeals, the MMP must render a decision within thirty (30) calendar days of the date that the appeal request has been received by the managed care entity. The MMP can extend the deadline for a decision by up to fourteen (14) days if requested by the beneficiary or if the delay is in the beneficiary's best interest.

c. Expedited appeals. For first -level internal appeals, the MMP must render a decision within seventy-two (72) hours of the date that the appeal request has been received by the managed care entity when either the MMP or the member's provider determines that standard appeal resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The MMP can extend the deadline for a decision by up to fourteen (14) days if requested by the beneficiary or if the delay is in the beneficiary's best interest.

1.7.8 MMP Benefit Package

A. The MMP provides a comprehensive benefit package to members that includes a full continuum of Medicare and Medicaid services as follows:

1. Medicare – Medicare Parts A, B, and D-funded medically necessary services.

2. Medicaid Services – The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered service is required and appropriate. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider. Medicaid services may be in-plan or out-of-plan. In-plan services are paid for on a capitated basis. Certain Medicaid-covered services are considered "out-of-plan" and are provided on a fee-for service basis. The MMP is not responsible for delivering or reimbursing out-of-plan services but is expected to coordinate in-plan services with out-of-plan services. Out-of-plan services are provided by existing Medicaid-approved providers who are reimbursed directly by Medicaid on a fee-for-service basis. The Medicaid coverage provided through the MMP is categorized as follows:

MMP Medicaid Benefits			
(a) In-Plan		**(b) Out-of-Plan**	
(01)	Inpatient Hospital Care	(01)	Dental Services
(02)	Outpatient Hospital Services	(02)	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS' non-emergency transportation broker)
(03)	Physical Therapy Evaluation and Services	(03)	Residential Services for Clients with Intellectual and Developmental Disabilities
(04)	Physician Services	(04)	
(05)	Care Management Services		
(06)	Family Planning Services		
(07)	Prescription Drugs		
(08)	Non-Prescription Drugs		
(09)	Laboratory Services		
(10)	Radiology Services		
(11)	Diagnostic Services		
(12)	Mental Health and		

MMP Medicaid Benefits		
(a) In-Plan		**(b) Out-of-Plan**
	Substance Use Disorder Treatment-Outpatient/Inpatient	
(13)	Home Health Services	
(14)	Emergency Room Service and Emergency Transportation Services	
(15)	Nursing Home Care and Skilled Nursing Facility Care	
(16)	Services of Other Practitioners	
(17)	Podiatry Services	
(18)	Optometry Services	
(19)	Oral Health	
(20)	Hospice Services	
(21)	Durable Medical Equipment	
(22)	Environmental Modifications (Home Accessibility Adaptations)	
(23)	Special Medical Equipment (Minor	

MMP Medicaid Benefits		
(a) In-Plan		**(b) Out-of-Plan**
	Assistive Devices)	
(24)	Adult Day Health	
(25)	Nutrition Services	
(26)	Group/Individual Education Programs	
(27)	Interpreter Services	
(28)	Transplant Services	
(29)	HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS and those that are at High Risk for Acquiring HIV	
(30)	AIDS Medical Case Management	
(31)	Court-ordered Mental Health and Substance Abuse Services – Criminal Court	
(32)	Court-ordered Mental Health and Substance Abuse Treatment – Civil Court	
(33)	Telemedicine	

MMP Medicaid Benefits		
(a) In-Plan		**(b) Out-of-Plan**
(34)	Preventive Services, including: Homemaker Personal Care Services Minor Environmental Modifications Physical Therapy Evaluation and Services Respite	
(35)	Long Term Services and Supports, including: Homemaker Meals on Wheels (Home Delivered Meals) Personal Emergency Response (PERS) Skilled Nursing Services (LPN Services) Community Transition Services Residential Supports Day Supports Supported Employment RIte @ Home (Supported Living Arrangements-	

MMP Medicaid Benefits		
(a) In-Plan		**(b) Out-of-Plan**
	Shared Living)* Private Duty Nursing Supports for Consumer Direction (Supports Facilitation) Self- Directed Goods and Services Financial Management Services (Fiscal Intermediary) Senior Companion (Adult Companion Services) Assisted Living Personal Care Assistance Services Respite Rehabilitation Services	
(36)	Opioid Treatment Provider Health Home	

1.8 Prescriptions: Generic Policy

A. For RHP and MMP enrolled members, Medicaid prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by the Medicaid agency, or the MCO acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below:

1. Availability of suitable within-class generic substitutes or out-of-class alternatives.

2. Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.

3. Relative disruptions in care that may be brought on by changing treatment from one drug to another.

4. Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.

5. Relative clinical advantages and disadvantages of drugs within a therapeutic class.

6. Cost differentials between brand and generic alternatives.

7. Drugs that are required under federal and State regulations.

8. Demonstrated medical necessity and lack of efficacy on a case by case basis.

B. For the MMP, the generic policy applies only to Medicaid covered drugs that are not part of the Medicare Part D formulary covered by the MMP. The MMP may cover brand name drugs as part of its Medicare Part D formulary, in accordance with Medicare Part D guidelines.

1.9 Non-Emergency Transportation Policy

Responsibility for transportation services rests first with the member. If the member's condition, place of residence, or the location of the medical provider does not permit the use of bus transportation, non-emergency transportation for the Medicaid enrollee may be arranged for by EOHHS, or its agent, in accordance with the provisions established in Part 20-00-2 of this Title.

1.10 Interpretation Services Policy

EOHHS will notify the health plan when it knows of members who do not speak English as a primary language who have either selected or been assigned to the plan. If more than fifty (50) members speak a single language, the RHP health plan must make available general written materials, such as its member handbook, in that language. If more than five percent (5%) or fifty (50) members, whichever is less, speak a single language, the MMP must make available general written materials, such as its member handbook, in that language. Interpreter services, including sign language interpreters, are covered for any

RHP or MMP member who speaks a non-English language as a primary language or who is deaf or hard of hearing.

1.11 Tracking, Follow-up, Outreach

Tracking, follow-up, and outreach services are provided by the health plan in association with an initial visit with the member's PCP, preventive visits and prenatal visits, referrals that result from preventive visits, and preventive dental visits. Outreach includes mail, phone, and home outreach, if necessary, for members who miss preventive and follow-up visits, and to resolve language, transportation, and other barriers to care.

1.12 Mainstreaming/Selective Contracting

The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of RHP and MMP. The MCO therefore must ensure that all of its network providers accept its members for treatment. The MCO also shall accept responsibility for ensuring that network providers do not intentionally segregate RHP and MMP members in any way from other persons receiving services. MCOs may develop selective contracting arrangements with certain providers for the purpose of cost containment but shall adhere to the access standards as defined in the MCO contracts.

1.13 Program of All-Inclusive Care for the Elderly (PACE)

1.13.1 Overview

PACE provides a managed plan of coordinated Medicare and Medicaid covered services from across the care continuum to certain beneficiaries age fifty-five (55) and older. The operations of PACE are bound by a three-way agreement between EOHHS, CMS, and the PACE provider to integrate the full range of Medicare (if eligible) and Medicaid services (primary care, acute care, specialty care, behavioral health care, and LTSS) for PACE participants.

1.13.2 EOHHS Responsibilities

EOHHS is responsible for the eligibility and enrollment functions set forth in § 1.13.4 of this Part, establishing PACE provider standards, and oversight and monitoring of all aspects of the PACE program.

1.13.3 PACE Provider Responsibilities

A. The PACE provider is responsible for:

1. Point of entry identification;

2. Submitting all necessary documentation for initial determinations and reevaluations of a level of need and referral to EOHHS for a determination of financial eligibility;

3. Verifying PACE enrollment prior to service delivery;

4. Verifying and collecting required beneficiary liability (cost-share amount);

5. Providing and coordinating all integrated services;

6. Reporting changes to the PACE-eligibility status of participants; and

7. Adhering to all PACE provider requirements as outlined in the PACE Program Agreement between EOHHS and CMS, and to all credentialing standards required by EOHHS including data submission.

1.13.4 PACE Participation Criteria

A. To qualify as a Medicaid-eligible PACE participant, an individual must:

1. Be fifty-five (55) years of age or older;

2. Meet the criteria for a high or the highest need for a nursing facility level of care in accordance with Part 50-00-5 of this Title; and

3. Meet all other financial and non-financial requirements for Medicaid LTSS such as, but not limited to, citizenship, residency, resources, income, and transfer of assets.

B. Medicaid-eligible PACE participants may be, but are not required to be, enrolled in Medicare.

1.13.5 PACE Disenrollment

A. Reasons for PACE Disenrollment – Reasons for disenrollment from PACE include but are not limited to:

1. Death;

2. Loss of Medicaid eligibility;

3. Eligibility error;

4. Placement in an out-of-state residential hospital;

5. Incarceration;

6. Change of state residence;

7. Loss of functional level of care; and

8. Voluntary opt-out to Medicaid FFS.

B. The PACE provider may also request in writing that a member be disenrolled on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members. In such instances, EOHHS will notify the PACE provider about its decision to approve or disapprove the disenrollment request within fifteen (15) days from the date EOHHS has received all information needed for a decision. Upon EOHHS approval of the disenrollment request, the PACE provider must, within three (3) business days, forward copies of a completed Disenrollment Request Form to EOHHS and to the Medicare enrollment agency (when appropriate). The PACE provider must also send written notification to the member that includes:

1. A statement that the PACE provider intends to disenroll the member;

2. The reason(s) for the intended disenrollment; and

3. A statement about the member's right to challenge the decision to disenroll and how to grieve or appeal such decision.

C. Disenrollment Requests Not Allowed. EOHHS does not permit disenrollment requests based on:

1. An adverse change in the member's health status;

2. The member's utilization of medical services; or

3. Uncooperative behavior resulting from the member's special needs.

D. Voluntary Disenrollment – PACE participants may voluntarily disenroll from PACE at any time. A voluntary disenrollment from PACE will become effective at midnight of the last day of the month in which the disenrollment is requested.

E. Disenrollment Process. Regardless of the reason for disenrollment, EOHHS is responsible for completing all disenrollment actions. Disenrollments requested by the PACE provider on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members are subject to EOHHS approval. Beneficiaries who are disenrolled from PACE but retain Medicaid eligibility will be enrolled in Medicaid fee-for-service and may subsequently choose or be enrolled in an

alternative service delivery if they qualify. Beneficiaries have the right to appeal EOHHS's disenrollment action (see Part 10-05-2 of this Title).

F. Disenrollment Effective Date. Regardless of the reason for disenrollment, all disenrollments from PACE will become effective at midnight of the last day of the month in which the disenrollment is requested.

1.13.6 Disenrollment Appeal

If the member files a written appeal of the disenrollment within ten (10) days of the decision to disenroll, the disenrollment shall be delayed until the appeal is resolved.

1.13.7 Re-enrollment and Transition Out of PACE

All re-enrollments will be treated as new enrollments except when a participant re-enrolls within two months after losing Medicaid eligibility. In this situation, the participant's re-enrollment will not be treated as a new enrollment. The PACE provider shall assist participants whose enrollment ceased for any reason in obtaining necessary transitional care through appropriate referrals, by making medical records available to the participant's new service providers, and (if applicable), by working with EOHHS to reinstate the participant's benefits.

1.14 PACE Benefit Package

A. CMS and EOHHS approve PACE providers who are responsible for providing the full scope of Medicare (if eligible) and Medicaid State Plan and waiver services, including but not limited to:

1. Multidisciplinary assessment and treatment planning;
2. Case Management services;
3. Personal Care;
4. Homemaking;
5. Rehabilitation;
6. Social Work;
7. Transportation;
8. Nutritional Counseling;
9. Recreational Therapy;

10. Minor Home Modifications; and

11. Specialized Medical Equipment and Supplies.

B. The PACE program is voluntary for any eligible person, but if an individual selects this program, he/she must get all medical and support services through PACE. There are no benefits outside of the PACE program.

1.15 Federal Poverty Limits (FPLs) 2019

Federal Poverty Level - 2019

Family Size	Percent of Poverty 100%	108%	110%	116%	125%	133%	138%	141%	145%	150%	155%	160%	175%	180%	185%	190%	195%
1	$ 12,490	$ 13,489	$ 13,739	$ 14,488	$ 15,613	$ 16,612	$ 17,236	$ 17,611	$ 18,111	$ 18,735	$ 19,360	$ 19,984	$ 21,858	$ 22,482	$ 23,107	$ 23,731	$ 24,356
2	$ 16,910	$ 18,263	$ 18,601	$ 19,616	$ 21,138	$ 22,490	$ 23,336	$ 23,843	$ 24,520	$ 25,365	$ 26,211	$ 27,056	$ 29,593	$ 30,438	$ 31,284	$ 32,129	$ 32,975
3	$ 21,330	$ 23,036	$ 23,463	$ 24,743	$ 26,663	$ 28,369	$ 29,435	$ 30,075	$ 30,929	$ 31,995	$ 33,062	$ 34,128	$ 37,328	$ 38,394	$ 39,461	$ 40,527	$ 41,594
4	$ 25,750	$ 27,810	$ 28,325	$ 29,870	$ 32,188	$ 34,248	$ 35,535	$ 36,308	$ 37,338	$ 38,625	$ 39,913	$ 41,200	$ 45,063	$ 46,350	$ 47,638	$ 48,925	$ 50,213
5	$ 30,170	$ 32,584	$ 33,187	$ 34,997	$ 37,713	$ 40,126	$ 41,635	$ 42,540	$ 43,747	$ 45,255	$ 46,764	$ 48,272	$ 52,798	$ 54,306	$ 55,815	$ 57,323	$ 58,832
6	$ 34,590	$ 37,357	$ 38,049	$ 40,124	$ 43,238	$ 46,005	$ 47,734	$ 48,772	$ 50,156	$ 51,885	$ 53,615	$ 55,344	$ 60,533	$ 62,262	$ 63,992	$ 65,721	$ 67,451
7	$ 39,010	$ 42,131	$ 42,911	$ 45,252	$ 48,763	$ 51,883	$ 53,834	$ 55,004	$ 56,565	$ 58,515	$ 60,466	$ 62,416	$ 68,268	$ 70,218	$ 72,169	$ 74,119	$ 76,070
8	$ 43,430	$ 46,904	$ 47,773	$ 50,379	$ 54,288	$ 57,762	$ 59,933	$ 61,236	$ 62,974	$ 65,145	$ 67,317	$ 69,488	$ 76,003	$ 78,174	$ 80,346	$ 82,517	$ 84,689

Federal Poverty Level - 2019

Family Size	Percent of Poverty 100%	200%	215%	220%	225%	250%	253%	261%	275%	300%	320%	325%	350%	400%
1	$ 12,490	$ 24,980	$ 26,854	$ 27,478	$ 28,103	$ 31,225	$ 31,600	$ 32,599	$ 34,348	$ 37,470	$ 39,968	$ 40,593	$ 43,715	$ 49,960
2	$ 16,910	$ 33,820	$ 36,357	$ 37,202	$ 38,048	$ 42,275	$ 42,782	$ 44,135	$ 46,503	$ 50,730	$ 54,112	$ 54,958	$ 59,185	$ 67,640
3	$ 21,330	$ 42,660	$ 45,860	$ 46,926	$ 47,993	$ 53,325	$ 53,965	$ 55,671	$ 58,658	$ 63,990	$ 68,256	$ 69,323	$ 74,655	$ 85,320
4	$ 25,750	$ 51,500	$ 55,363	$ 56,650	$ 57,938	$ 64,375	$ 65,148	$ 67,208	$ 70,813	$ 77,250	$ 82,400	$ 83,688	$ 90,125	$ 103,000
5	$ 30,170	$ 60,340	$ 64,866	$ 66,374	$ 67,883	$ 75,425	$ 76,330	$ 78,744	$ 82,968	$ 90,510	$ 96,544	$ 98,053	$ 105,595	$ 120,680
6	$ 34,590	$ 69,180	$ 74,369	$ 76,098	$ 77,828	$ 86,475	$ 87,513	$ 90,280	$ 95,123	$ 103,770	$ 110,688	$ 112,418	$ 121,065	$ 138,360
7	$ 39,010	$ 78,020	$ 83,872	$ 85,822	$ 87,773	$ 97,525	$ 98,695	$ 101,816	$ 107,278	$ 117,030	$ 124,832	$ 126,783	$ 136,535	$ 156,040
8	$ 43,430	$ 86,860	$ 93,375	$ 95,546	$ 97,718	$ 108,575	$ 109,878	$ 113,352	$ 119,433	$ 130,290	$ 138,976	$ 141,148	$ 152,005	$ 173,720

Federal Poverty Level - 2019 - Monthly

Family Size	Percent of Poverty 100%	108%	110%	116%	125%	133%	138%	141%	145%	150%	155%	160%	175%	180%	185%	190%	195%
1	$ 1,040.83	$ 1,124.10	$ 1,144.92	$ 1,207.37	$ 1,301.04	$ 1,384.31	$ 1,436.35	$ 1,467.58	$ 1,509.21	$ 1,561.25	$ 1,613.29	$ 1,665.33	$ 1,821.46	$ 1,873.50	$ 1,925.54	$ 1,977.58	$ 2,029.63
2	$ 1,409.17	$ 1,521.90	$ 1,550.08	$ 1,634.63	$ 1,761.46	$ 1,874.19	$ 1,944.65	$ 1,986.93	$ 2,043.29	$ 2,113.75	$ 2,184.21	$ 2,254.67	$ 2,466.04	$ 2,536.50	$ 2,606.96	$ 2,677.42	$ 2,747.88
3	$ 1,777.50	$ 1,919.70	$ 1,955.25	$ 2,061.90	$ 2,221.88	$ 2,364.08	$ 2,452.95	$ 2,506.28	$ 2,577.38	$ 2,666.25	$ 2,755.13	$ 2,844.00	$ 3,110.63	$ 3,199.50	$ 3,288.38	$ 3,377.25	$ 3,466.13
4	$ 2,145.83	$ 2,317.50	$ 2,360.42	$ 2,489.17	$ 2,682.29	$ 2,853.96	$ 2,961.25	$ 3,025.63	$ 3,111.46	$ 3,218.75	$ 3,326.04	$ 3,433.33	$ 3,755.21	$ 3,862.50	$ 3,969.79	$ 4,077.08	$ 4,184.38
5	$ 2,514.17	$ 2,715.30	$ 2,765.58	$ 2,916.43	$ 3,142.71	$ 3,343.84	$ 3,469.55	$ 3,544.98	$ 3,645.54	$ 3,771.25	$ 3,896.96	$ 4,022.67	$ 4,399.79	$ 4,525.50	$ 4,651.21	$ 4,776.92	$ 4,902.63
6	$ 2,882.50	$ 3,113.10	$ 3,170.75	$ 3,343.70	$ 3,603.13	$ 3,833.73	$ 3,977.85	$ 4,064.33	$ 4,179.63	$ 4,323.75	$ 4,467.88	$ 4,612.00	$ 5,044.38	$ 5,188.50	$ 5,332.63	$ 5,476.75	$ 5,620.88
7	$ 3,250.83	$ 3,510.90	$ 3,575.92	$ 3,770.97	$ 4,063.54	$ 4,323.61	$ 4,486.15	$ 4,583.68	$ 4,713.71	$ 4,876.25	$ 5,038.79	$ 5,201.33	$ 5,688.96	$ 5,851.50	$ 6,014.04	$ 6,176.58	$ 6,339.13
8	$ 3,619.17	$ 3,908.70	$ 3,981.08	$ 4,198.23	$ 4,523.96	$ 4,813.49	$ 4,994.45	$ 5,103.03	$ 5,247.79	$ 5,428.75	$ 5,609.71	$ 5,790.67	$ 6,333.54	$ 6,514.50	$ 6,695.46	$ 6,876.42	$ 7,057.38

Federal Poverty Level - 2019 - Monthly

Family Size	Percent of Poverty 100%	200%	215%	220%	225%	250%	253%	261%	275%	300%	320%	325%	350%	400%
1	$ 1,040.83	$ 2,081.67	$ 2,237.79	$ 2,289.83	$ 2,341.88	$ 2,602.08	$ 2,633.31	$ 2,716.58	$ 2,862.29	$ 3,122.50	$ 3,330.67	$ 3,382.71	$ 3,642.92	$ 4,163.33
2	$ 1,409.17	$ 2,818.33	$ 3,029.71	$ 3,100.17	$ 3,170.63	$ 3,522.92	$ 3,565.19	$ 3,677.93	$ 3,875.21	$ 4,227.50	$ 4,509.33	$ 4,579.79	$ 4,932.08	$ 5,636.67
3	$ 1,777.50	$ 3,555.00	$ 3,821.63	$ 3,910.50	$ 3,999.38	$ 4,443.75	$ 4,497.08	$ 4,639.28	$ 4,888.13	$ 5,332.50	$ 5,688.00	$ 5,776.88	$ 6,221.25	$ 7,110.00
4	$ 2,145.83	$ 4,291.67	$ 4,613.54	$ 4,720.83	$ 4,828.13	$ 5,364.58	$ 5,428.96	$ 5,600.63	$ 5,901.04	$ 6,437.50	$ 6,866.67	$ 6,973.96	$ 7,510.42	$ 8,583.33
5	$ 2,514.17	$ 5,028.33	$ 5,405.46	$ 5,531.17	$ 5,656.88	$ 6,285.42	$ 6,360.84	$ 6,561.98	$ 6,913.96	$ 7,542.50	$ 8,045.33	$ 8,171.04	$ 8,799.58	$ 10,056.67
6	$ 2,882.50	$ 5,765.00	$ 6,197.38	$ 6,341.50	$ 6,485.63	$ 7,206.25	$ 7,292.73	$ 7,523.33	$ 7,926.88	$ 8,647.50	$ 9,224.00	$ 9,368.13	$ 10,088.75	$ 11,530.00
7	$ 3,250.83	$ 6,501.67	$ 6,989.29	$ 7,151.83	$ 7,314.38	$ 8,127.08	$ 8,224.61	$ 8,484.68	$ 8,939.79	$ 9,752.50	$ 10,402.67	$ 10,565.21	$ 11,377.92	$ 13,003.33
8	$ 3,619.17	$ 7,238.33	$ 7,781.21	$ 7,962.17	$ 8,143.13	$ 9,047.92	$ 9,156.49	$ 9,446.03	$ 9,952.71	$ 10,857.50	$ 11,581.33	$ 11,762.29	$ 12,667.08	$ 14,476.67

210-RICR-40-10-1

TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 40 - MEDICAID FOR ELDERS AND ADULTS WITH DISABILITIES

SUBCHAPTER 10 - MANAGED CARE

PART 1 - MEDICAID MANAGED CARE SERVICE DELIVERY ARRANGEMENTS (210-RICR-40-10-1)

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E-SIGNED by Womazetta Jones on 2020-03-24 14:48:58 GMT — March 24, 2020

Agency Head Signature — Agency Signing Date

Governor's Signature

Claire Richards

Signed By

E-SIGNED by Office of the Governor on 2020-03-24 20:46:29 GMT — March 24, 2020

Governor or Designee — Governor Signing Date

Department of State

03/24/2020

Regulation Effective Date

K.C. — March 25, 2020

Department of State Initials — Department of State Date