210-RICR-30-00-3

TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 30 – MEDICAID FOR CHILDREN, FAMILIES AND AFFORDABLE CARE ACT (ACA) ADULTS

SUBCHAPTER 00 – AFFORDABLE COVERAGE GROUPS

PART 3 – Medicaid Application and Renewal Process

3.1 Application Process for Medicaid Affordable Coverage: No Wrong Door

3.1.1 Scope, Purpose, and Legal Authority

A. One of the central goals of the federal Affordable Coverage Act (hereinafter the ACA) of 2010 (Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq*.) was to improve access to and the availability of affordable health coverage. Toward this end, the ACA mandated that the States reform the Medicaid application and renewal system to make it easier for consumers to navigate and gain access to and retain affordable health care coverage.

B. The purpose of this Rule is to set forth the application and renewal processes for members of the Medicaid Affordable Care Coverage (MACC) groups subject to MAGI-based income eligibility determinations. The Rule also sets forth the respective roles and responsibilities of the EOHHS, its eligibility agents, and applicants/beneficiaries. In addition, the Rule establishes the application and renewal processes for children in the Integrated Health Care Coverage (IHCC) groups who are exempt from MAGI determinations under Federal law and Regulations and, therefore, the Medicaid State Plan because their eligibility is tied to participation in other publicly funded programs including Federal Supplemental Security Income (SSI), and the programs for children and youth at-risk or in the custody of the Rhode Island Department of Children, Youth and Families (DCYF).

C. This Part is promulgated pursuant to:

1. Federal authorities as follows:

    a. Federal Laws – Title IVE, Title XIX, and Title XXI of the U.S. Social Security Act and ACA.

    b. Federal Regulations – 42 C.F.R. §§ 435.603; 435.902 through 910; 435.916; and 435.1025

c. The Medicaid State Plan and the Title XIX, Section 1115(a) Demonstration Waiver (11-W-00242/1), effective through December 31, 2018.

2. State authorities – R.I. Gen. Laws Chapters 40-6, 40-8, and 42-7.2.

3.1.2 Definitions

A. As used herein, the terms below have the meanings described:

1. "Application access points" means the various contact points where consumers or their representatives can access the application process either directly through the State's integrated eligibility system's consumer portal (online) or with the assistance of EOHHS, the Department of Human Services (DHS), or HealthSource RI (HSRI) representatives, or an application entity designated by the State for such purposes (in-person, by telephone or a mail-in application).

2. "Application entity" means an organization or firm acting on a State agency's behalf that provides applicants for affordable coverage with an application access point including the EOHHS, the DHS, the HealthSource RI (HSRI) and any organizations designated for such purposes that maintain a staff of certified navigators or in-person assistors.

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

4. "Integrated Health and Human Services Eligibility System" or "IES" means the State's eligibility system that enables applicants, through a single application, to be considered for several human service programs simultaneously, including affordable health coverage and human services.

5. "Medicaid Affordable Care Coverage Group" 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 set forth in Part 1 of this Subchapter.

6. "MAGI standard" means the method for evaluating Medicaid income eligibility using the modified adjusted gross income (MAGI) standard established under the ACA. The MAGI is the standard for determining income eligibility for all MACC groups.

7. "Modified passive renewal" means a method for determining continuing eligibility using electronic data sources and information provided by beneficiaries. This method is only used when the eligibility factors subject to change cannot be evaluated fully by the available electronic data sources or information in the beneficiary's account. This process may also be used when there is insufficient information to determine whether a

beneficiary who is losing coverage due to a change in an eligibility factor is eligible in another coverage group, such as when a MACC adult is about to turn sixty-five (65) and must be evaluated using the SSI methodology specified in Chapter 40 of this Title.

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

9. "Non-MAGI coverage group" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. For the purposes of this Part, the term refers to the children and youth who are eligible for Medicaid based on their participation in another publicly funded program and/or by Federal law, including infants born to Medicaid eligible mothers, recipients of Supplemental Security Income (SSI) cash assistance under age twenty-one (21), and children and youth who are, or in some instances were, in the care and/or custody of the Rhode Island Department of Children, Youth and Families (DCYF).

10. "Passive or *ex parte* renewal" means a method for determining continuing eligibility that uses electronic data sources to confirm ongoing eligibility without information or action on the part of a beneficiary, unless certain types of discrepancies are detected. The State may require members to resolve discrepancies in pre-populated forms or in online accounts.

3.1.3 Application Access Points

A. Under the State's "No Wrong Door Policy", consumers must have easy access to a choice of application access points. New applicants for affordable coverage may access the eligibility system and complete the application process through application entities that have been designated for this purpose and on their own or with assistance, if necessary, through any of the following access points:

1. Online Consumer Portal – Applicants have the option of accessing the eligibility system and applying online using a self-service portal through links on the EOHHS (eohhs.ri.gov) and DHS (dhs.ri.gov) websites or directly through HSRI (HealthSourceRI.com). The information applicants provide is entered directly into the IES and is processed electronically in real-time.

2. In-person or by telephone – Applicants may apply in-person at DHS field offices with the assistance of an agency representative or on their own using kiosks established for this purpose. The Contact Center also provides access to walk-in applicants and consumers who make contact by telephone. If an applicant is unwilling or unable to apply online, an agency or Contact Center representative must enter the information into the IES on the applicant's behalf.

3. On-paper – Applicants may submit paper applications in-person or by U.S. Mail, e-mail transmissions, and facsimile transmissions to the address specified on the application. Paper applications are available online, through the U.S. Mail upon written request or telephone request (1-855-840-4774 or 1-888-657-3173 (TTY)), or in-person at any DHS field office or the Contact Center. Upon receipt, an agency or Contact Center representative must enter the information provided on the paper application directly into the eligibility system portal and submit the application for a determination on the applicant's behalf.

4. Application Entities – Applicants may access the eligibility system with the assistance of application entities that provide navigators or other in-person assisters (IPAs). Members of these entities assist applicants in completing paper applications or applying through the online portal. A list of these application entities is available from the Contact Center or online by visiting the EOHHS website (www.eohhs.ri.gov).

3.1.4 Completing and Submitting the Application

A. In general, the process of completing and submitting an application proceeds in accordance with the following:

1. Account Creation – To initiate the application process, the applicant, agency or Contact Center representative, or application entity assisting the applicant, must create a login and establish an account in the eligibility system.

   a. The applicant must provide personally identifiable information for the purpose of creating an online account and establishing identity during this process. Verification of this information is automated through the Federal data hub (see § 30-00-5.7 of this Title). Documentation verifying identity may be required if the automated verification process is unsuccessful. Acceptable forms of identity proof include, but are not limited to, a driver's license, school registration, voter registration card. Documents may be submitted via mail, fax, on-line upload, to a DHS Office, or the HSRI. (See Part 30-00-5.7 of this Title for additional information).

   b. Once identity is verified, the Medicaid agency must conduct account matches to determine whether the applicant or members of the applicant's household have other accounts or are currently receiving benefits. It is the State's responsibility to resolve account matching issues and notify the applicant of any necessary actions.

2. Account Duration – An application account is open for a period of ninety (90) days. Applicants must restart the process if they have not completed and submitted an application within that period.

a. Applications may be started at any time. Once started, progress can be saved at any point and the application returned to at a later time. Incomplete applications not submitted within ninety (90) days are automatically deleted in the eligibility system.

b. Eligibility determinations for Medicaid. Determinations must be made within thirty (30) days from the date the completed application is received. The application remains open after that period if the State or its eligibility designee (DHS) or agents (application entities) are responsible for delays in the eligibility determination.

c. Temporary eligibility period. If there are discrepancies between an applicant's attestations and electronic data matches on immigration eligibility factors, eligibility is granted for a period of no more than ninety (90) days. The application remains open during this period to allow the applicant sufficient time to obtain necessary documentation.

3. Application Materials – Applicants must answer all the required questions for each member of their household. Application questions focus on the need for all types of affordable coverage and specific Medicaid eligibility criteria related to the applicable MACC group. In general, applicants will be able to provide answers to the application questions with information used when filing Federal tax forms and/or documents commonly used for identification and income verification purposes. When applying through the web portal online, electronic verification through data matches will limit the applicant's need to refer to these materials. However, when using a paper application, access to these materials may be necessary. Materials that may be of assistance in such instances include, but are not limited to:

a. Federal tax filing status

b. Household/family size

c. Social Security Numbers

d. Birth dates

e. Passport or other immigration numbers

f. Federal tax returns

g. Information about any health coverage available to you or your family, including any information you have about the health insurance your current employer offers even if you are not covered by your employer's insurance plan

h. W-2 forms with salary and wage information if you work for an employer

i. 1099 forms, if you are self-employed.

4. Application Completeness – Before a determination of eligibility is made, all questions on the application must be completed. Applicants must be informed and offered the opportunity to provide any additional documentation or explanations necessary to proceed to the determination of eligibility. Such information will be provided to applicants immediately through a notification from the eligibility system when using the self-service portal. The agency or HSRI, or application entity entering the information into the eligibility system on the applicant's behalf, must provide this information to the applicant immediately once it becomes available, by letter or phone if the applicant is not present. However, the application filing date is not established until the completed form is submitted.

5. Voluntary Withdrawal. An applicant may request that an application for Medicaid health coverage be withdrawn at any time either through their secure online account or by submitting the request in writing via the U.S. Mail or fax to the EOHHS or DHS agency or a HSRI representative. Withdrawal of the application may also be made by telephone to the HSRI. The State sends a notice to the applicant verifying the time and date of the voluntary withdrawal and indicating that the applicant may reapply at any time.

3.1.5 Attestation of Application Information

A. All questions on the application must be answered in a truthful and accurate manner. Every applicant must self-attest to the truthfulness and accuracy of the question responses and documentation submitted by providing an electronic signature under penalty of perjury.

1. Electronic Matches – Federal and State Data Sources: The eligibility system verifies attestations through electronic data matches to the fullest extent feasible with external sources such as the U.S. Social Security Administration (SSA) and Internal Revenue Service (IRS) and Rhode Island agencies such as the Division of Motor Vehicles (DMV), the Office of Vital Statistics and the Department of Labor and Training (DLT). The eligibility factors subject to verification and the verification process is located in § 5.7 of this Subchapter.

2. Attestation – Before an application can be submitted, the applicant, or the person/entity acting on the applicant's behalf, must authenticate by signature that the information provided is genuine, correct, and true. When applying online, the attestation is conducted electronically. An agency or

HSRI representative or an authorized application entity must verify that the application was signed (mail application), a voice signature was obtained (telephone application), or that the applicant signed a declaration in-person. The signature provided by the applicant in these instances is an attestation to both the applicant's identity and the truthfulness and accuracy of the information on the application. There are circumstances when an applicant's attestations and verification data matches show discrepancies. (See §§ 5.8 through 5.10 of this Subchapter for the provisions governing reconciliation of such differences).

3.1.6 Privacy of Application Information

Application information must only be used to determine eligibility and what types of coverage a person is qualified to receive. Accordingly, the State, HSRI, or application entity must maintain the privacy and confidentiality of all application information and in the manner required by applicable Federal and State laws and Regulations and as provided in Part 10-05-1 of this Title.

3.1.7 Notice of Determination of Eligibility

A. Once an application is completed and the required verifications are performed, eligibility for Medicaid and other forms of affordable coverage is made for each member of the household. (For information on other forms of affordable coverage, see www.HealthSourceRI.com or call HSRI at 1-855-840-4774).

B. Household members determined Medicaid-eligible may enroll immediately in the health plan of choice. A formal notice will be generated after the determination indicating which household members are eligible for Medicaid or other forms of affordable coverage, the legal basis for the determination of eligibility, and the plan in which each household member is enrolled, if applicable. The notice will be sent via the applicant's secure online account if opting to receive agency communications in such a manner or by mail in a reasonable time period. A "reasonable time" period usually will not exceed ten (10) business days, but in no instance will it extend beyond the thirty (30) day application period.

C. The notice must also advise the applicant of the right to appeal and request a hearing, in accordance with Part 10-05-2 of this Title.

3.1.8 Agency and Applicant Roles and Responsibilities

A. The State and applicants have shared and distinct responsibilities in the application process.

1. Medicaid agency – Under current State and Federal laws, the Medicaid State Agency is required to:

a. Assist applicants in completing all necessary forms.

b. Provide applicants with an interpreter or translator services upon request.

c. Assure all information applicants provide is kept confidential unless otherwise authorized to share with other State and Federal agencies for the purposes of verification and enrollment.

d. Make timely determinations of eligibility in accordance with applicable laws and Regulations.

e. Accept appeals and hold hearings on agency actions related to eligibility decisions in accordance with Part 10-05-2 of this Title.

f. Provide a mechanism for beneficiaries to voluntarily withdraw eligibility for Medicaid health coverage at any time by submitting a written request via the U.S. Mail or fax to the EOHHS or DHS agency or an HSRI representative.

2. Applicant Rights and Responsibilities – All applicants have the following:

a. Applicant Rights – The right to obtain help in completing forms; to an interpreter or translator, upon request; to be treated free from discrimination on the basis of race, color, national origin, sex, gender identity or sexual orientation, age or disability; to have personal information remain confidential; and to file an appeal and request a hearing on eligibility actions.

b. Applicant Responsibilities – The responsibility to:

(1) Disclose certain information including Social Security Numbers and proof necessary to determine eligibility;

(2) Report changes in income, family size and other application information as soon as possible; and

(3) Sign the application and thereby agree to comply with any applicable laws related to the type of eligibility requested and the coverage received.

3.2 Renewal of Eligibility for Medicaid Affordable Care Coverage Groups

3.2.1 Scope and Purpose

All MACC group members are subject to MAGI-based renewals, focusing on the eligibility factors subject to change. Such factors include changes in income, household composition or family size (due to death, marital status, birth or adoption of child), and/or State residency. Disenrollments for any reason that are

followed by requests for eligibility reinstatements are also subject to this process for members of the MACC groups.

3.2.2 Responsibilities of the State

A. The State is responsible to ensure that the Medicaid renewal process occurs once every twelve (12) months for all MACC group members. EOHHS will postpone the processing of annual Medicaid eligibility renewals that would result in a termination of Medicaid eligibility that fall during the novel Coronavirus Disease (COVID-19) declaration of emergency. This includes the suspension of eligibility determinations based on information gathered from periodic data checks for unemployment, SWICA, TALX and other sources and suspension of quarterly post-eligibility verifications. These provisions will not cease upon the termination of the State-declared Public Health Emergency, in order to ensure the continuation of EOHHS' eligibility for enhanced Federal funding. In anticipation of the termination of the Federal declaration of the COVID-19 public health emergency (PHE), EOHHS will begin requesting information from Medicaid eligible members for annual Medicaid eligibility renewals that were postponed due to the COVID-19 PHE prior to the termination of the Federal declaration of the COVID-19 PHE. EOHHS will not terminate any Medicaid eligible individual, unless the individual has moved out of State, they requested to be disenrolled, or the individual is deceased, until after the termination of the Federal declaration of the COVID-19 PHE. Towards this end, the State must meet the following requirements:

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

2. Restrictions – The State must not request or use information when conducting renewals pertaining to: eligibility factors that are not subject to change or concern matters that are not relevant to continuation of Medicaid eligibility. Eligibility factors subject to change include income, household or family size, State residency and certain immigration statuses. Factors that are not subject to change include, but are not limited to, native born or naturalized U.S. citizenship, date of birth, and Social Security Number.

3. Renewal Strategy – The State utilizes a passive "*ex parte*" renewal process for all MACC group members when determining continuing eligibility and whether a beneficiary who is losing coverage due to a change in an eligibility factor qualifies for Medicaid in another coverage group to the full extent feasible. This renewal method confirms eligibility

factors subject to change through electronic data sources and only requires action on the part of the beneficiary if certain discrepancies are detected by the State or self-reported. The State will use both active and passive renewal methods until all MACC group members have been subject to a MAGI-based income eligibility determination at least once. Accordingly, the State will conduct renewals as follows:

a. Initial review. The State redetermines eligibility at least sixty (60) days before the renewal date using information known to the IES and from various data sources and provides notice to the beneficiary indicating the results of this review. The notice contains the information that served as the basis for this eligibility review and indicates one (1) of the following:

   (1) Passive *Ex Parte* Renewal – Medicaid eligibility has been renewed "*ex parte*" and no further action on the part of the beneficiary is required unless, upon reviewing the information in the notice, the beneficiary identifies an error or a change in an eligibility factor subject to change that must be reported to the State; or

   (2) Modified Passive Renewal – Medicaid eligibility has not been renewed due to missing information or a discrepancy between sources of information related to an eligibility factor subject to change. In such instances, the notice contains an additional documentation request (ADR) specifying the type of information that must be submitted for the renewal of eligibility to proceed.

b. Renewal decision. If the beneficiary is not required to take any action and does not find cause to self-report a change, Medicaid eligibility is continued automatically for another year, effective on the renewal date. However, in order to be considered in this final renewal decision, change self-reports and ADR responses must submitted at least thirty (30) days from the date of the renewal notice. The State redetermines eligibility based on this information. If the beneficiary receives an ADR and does not take the action required, this redetermination is based solely on the information known to the IES through self-attestations and applicable data sources. A formal notice is issued with the State's final renewal decision if eligibility is discontinued on this basis at least fifteen (15) days prior to the eligibility continuation or termination date. Information received by the State at any time prior to the eligibility termination date is considered. However, if the information is submitted after the tenth day of the renewal month, a change from managed care to fee-for-service service delivery may result.

c. Reinstatement. A reinstatement of Medicaid eligibility is permitted without a full reapplication, in instances in which a beneficiary takes the actions required to resolve a discrepancy or information gap in the ninety (90) day period after eligibility is terminated.

4. Consent – The State must obtain the consent of the Medicaid member to retrieve and verify electronically information related to eligibility factors subject to change including any federal tax information required to review income eligibility. Such consent is obtained during the initial application for Medicaid eligibility when the Medicaid member signs the application, under penalty of perjury.

5. Enrollment – A Medicaid member whose eligibility has been continued through the annual renewal process must remain in the same Medicaid health plan unless the renewal occurs during an open enrollment period. If an open enrollment process is not underway at the time of renewal, the provisions set forth in Subchapter 05 Part 2 of this Chapter prevail.

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

3.2.3 Responsibilities of Medicaid Members

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

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

2. Duty to Report -- Medicaid members are required to report changes in eligibility factors to the Medicaid agency within ten (10) days from the date the change takes effect. Self-reports are permitted through the eligibility system on-line portal. Medicaid members also may report such changes in person, via fax, by mail, or telephone with the assistance of HSRI, DHS agency representative, or Navigator. Failure to report in a timely manner, as noted above, may result in the discontinuation of Medicaid eligibility.

3. Cooperation – Medicaid members must provide any documentation that otherwise cannot be obtained related to any eligibility factors subject to change when requested by the State. The information must be provided

within the timeframe specified by the State in the notice to the Medicaid member stating the basis for making the agency's request.

4. Voluntary Termination – A Medicaid member may request to be disenrolled from a Medicaid health plan or to terminate Medicaid eligibility at any time. Disenrollment results in the termination of Medicaid eligibility.

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

3.3 Information

3.3.1 For Further Information or to Obtain Assistance

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

1. www.eohhs.ri.gov

2. www.dhs.ri.gov

3. www.HealthSourceRI.com

B. Applicants may also apply in person at one of the DHS offices or by U.S. Mail. Request an application by calling 1-855-840-4774 or TTY 1-888-657-3173.

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

3.4 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.

210-RICR-30-00-3

TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 30 - MEDICAID FOR CHILDREN, FAMILIES, AND AFFORDABLE CARE ACT (ACA) ADULTS

SUBCHAPTER 00 - AFFORDABLE COVERAGE GROUPS

PART 3 - MEDICAID APPLICATION AND RENEWAL PROCESSES 210-RICR-30-00-3

Type of Filing: Refile Capabilities

Department of State

01/04/2022	09/15/2021
Regulation Effective Date	Original Signing Date
E-SIGNED by Department of State on 2021-12-15 15:11:43 EST	December 15, 2021
Department of State Initials	Department of State Date