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TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 10 – EOHHS GENERAL PROVISIONS

SUBCHAPTER 00 - GENERAL PROVISIONS

PART 1 - OVERVIEW OF THE RHODE ISLAND MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAMS

1.1 Statutory Authority of the State Agency

A. R.I. Gen. Laws § 42-7.2-2 created the Rhode Island Executive Office of Health and Human Services (EOHHS) in 2006. EOHHS serves "as the principal agency of the executive branch of state government for managing the departments of children, youth and families, health, human services, and behavioral healthcare, developmental disabilities and hospitals."

B. EOHHS is responsible for administering the State's Medicaid program, which provides health care services and supports to a significant number of Rhode Islanders on an annual basis.

C. The statutory foundations of the Rhode Island Medicaid program are Title XIX of the Social Security Act (42 U.S.C. § 1396a *et seq*.), and R.I. Gen. Laws Chapters 40-8 and 42-7.2. Statutory authority for health care coverage funded in whole or in part by the federal Children's Health Insurance Program (CHIP) is derived from 42 U.S.C. § 1397aa *et seq*., of the U.S. Social Security Act, which establishes that program and provides the legal basis for providing health coverage, services and supports to certain targeted low-income children and pregnant women through Medicaid.

D. EOHHS is designated as the "single state agency", authorized under Title XIX and, as such, is legally responsible for the fiscal management and administration of the Medicaid program. As health care coverage funded by CHIP is administered through the State's Medicaid program, EOHHS also serves as the CHIP State Agency under federal and State laws and regulations.

E. The Medicaid and CHIP State Plans and the Rhode Island's Medicaid Section 1115 demonstration waiver provide the necessary authorities for the health care administered through the Medicaid program and establish the respective roles and responsibilities of beneficiaries, providers, and the State.

1.2 Definitions

A. As used herein, these definitions have the following meaning:

1. "CHIP State Plan" means the State of Rhode Island's State Plan identifying the eligibility categories and services authorized for federal financial participation under Title XIX of the federal Social Security Act establishing the Children's Health Insurance Program (CHIP).

2. "Executive Office of Health and Human Services" or "EOHHS" means the state agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 within the executive branch of state government and serves as the principal agency for the purposes of managing the Departments of Children, Youth, and Families (DCYF); Health (RIDOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). EOHHS is designated as the "single state agency," authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

3. "Medicaid State Plan" means State of Rhode Island's State Plan identifying the eligibility categories and services authorized for federal financial participation under Title XIX of the federal Social Security Act establishing the Medicaid program.

4. "State agency" means EOHHS.

1.3 Purposes and Scope of the Medicaid Program

A. The Rhode Island Medicaid program is the joint federal/state health care program that provides publicly funded health coverage to low-income individuals and families, adults without dependent children age nineteen (19) to sixty-four (64), elders, and persons with disabilities who otherwise cannot afford or obtain the services and supports they need to live safe and healthy lives.

B. Eligibility -- Coverage Groups. A coverage group is a classification of individuals eligible to receive Medicaid benefits based on a shared characteristic such as age, income, health status, and level of need criteria. Pursuant to the authority provided under the Medicaid and CHIP State Plans and the State's Section 1115 demonstration waiver, health coverage, services, and supports are available to individuals and families who meet the eligibility requirements for the following coverage groups:

1. Medicaid Affordable Care Coverage (MACC) Groups –A single income standard – Modified Adjusted Gross Income or "MAGI" – must be used to determine the eligibility of all applicants under the Medicaid affordable care coverage groups, which are as follows:

    a. Families with children and young adults, pregnant women, infants and parents/caretakers with income up to the levels sets forth in Part 30-00-3 of this Title;

b. Adults between the ages of nineteen (19) and sixty-four (64) without dependent children who meet the income limits set forth in the Part 30-00-3 of this Title, including any persons in this age group who are awaiting a determination of eligibility for Medicaid on the basis of age, blindness, or disability pursuant to Part 40-05-1 of this Title or receipt of Supplemental Security Income (SSI) pursuant to Part 40-00-3 of this Title;

2. Integrated Health Care Coverage (IHCC) Groups – All applicants for Medicaid who must meet both clinical and financial eligibility requirements or who are eligible based on their participation in another needs-based, federally funded health and human services program are not subject to the MAGI. The State has reclassified these categorically and medically needy populations into coverage groups based on shared eligibility characteristics, level of need, and/or access to integrated care options as follows:

a. Adults between the ages the ages of nineteen (19) and sixty-four (64) who are blind or disabled and elders age sixty-five (65) and older who meet the financial and clinical eligibility for Medicaid-funded coverage established pursuant Part 40-05-1 of this Title;

b. Persons of any age who require long-term services and supports in an institutional or home and community-based setting who meet the financial and clinical criteria established pursuant to the Parts 50-00-6 and 50-00-5 of this Title, respectively, or in the case of children eligible under the Katie Beckett provision, who meet the criteria in the Part 50-10-3 of this Title;

c. Individuals eligible for Medicaid-funded health coverage on the basis of their participation in another publicly funded program including children and young adults receiving services authorized by the Department of Children, Youth and Families and persons of any age who are eligible on the basis of receipt of SSI benefits.

d. Medically needy individuals who meet all the eligibility criteria for coverage except for excess income. Individuals in this coverage group achieve eligibility by applying a flexible test of income which applies excess income to certain allowable medical expenses thereby enabling the individual to “spend down” to within a medically needy income limit (MNIL) established by the Medicaid agency.

e. Low-income elders and persons with disabilities who qualify for the Medicare Premium Payment Program (MPP) authorized by the Title XIX. Medicaid pays the Medicare Part A and/or Part B premiums for MPP beneficiaries.

C. Benefits. Medicaid beneficiaries are eligible for the full scope of services and supports authorized by the Medicaid State Plan and the Section 1115 demonstration waiver.

1. General scope of coverage. Although there is variation in benefits by coverage group, in general Medicaid health coverage includes the following:

- Doctor's office visits
- Immunizations
- Prescription and over-the-counter medications
- Lab tests
- Residential treatment
- Behavioral health services
- Drug or alcohol treatment
- Early and Periodic, Screening, Detection and Treatment (EPSDT)
- Referral to specialists
- Hospital care
- Emergency care
- Urgent Care
- Long-term Services and Supports (LTSS) in home and community-based and health care institutional settings such as nursing homes
- Home health care
- Skilled nursing care
- Nutrition services
- Interpreter services
- Childbirth education programs
- Prenatal and post-partum care
- Parenting classes
- Smoking cessation programs
- Transportation services
- Dental care
- Expedited LTSS
- Organ transplants
- Durable Medical Equipment

2. EPSDT. Title XIX authorizes Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for all Medicaid beneficiaries who are under age twenty-one (21) for the purposes of identifying and treating behavioral health illnesses and conditions. Medically necessary EPSDT services must be provided irrespective of whether they are within the scope of Medicaid State Plan covered services.

3. Limits. Certain benefits covered by the Medicaid State Plan or the State's Section 1115 waiver are subject to limits under federal and/or State law. Program-wide benefit limits are set forth in § 1.5 of this Part. Limits and restrictions applicable to specific coverage groups are located in the rules describing the coverage group and service delivery.

1.4 Program Administration

A. Applications and Eligibility. EOHHS implements a "no wrong door" policy to ensure persons seeking eligibility for Medicaid health care coverage have the option to apply at multiple locations throughout the State and in a manner that is best suited to their needs including, but not limited to, in-person, on-line, by telephone, or by U.S. mail. Application and eligibility information for the MACC groups is located in the Part 30-00-3 of this Title. An overview of the application process for the IHCC groups is located in Part 40-00-1 of this Title.

1. Determinations. EOHHS must make timely and efficient eligibility, enrollment, and renewal decisions. Accordingly, EOHHS or an entity designated by the Secretary for such purposes must review and make eligibility and renewal determinations for Medicaid health care coverage in accordance with applicable State and federal laws, rules, and regulations.

2. Timeliness. In general, determinations must be made in no more than thirty (30) days from the date a completed application is received by EOHHS or its designee unless clinical eligibility factors must be considered. In instances in which both clinical and financial eligibility factors are material to the application process, as for eligibility for Medicaid-funded LTSS or coverage for persons with disabilities, determinations must be made in ninety (90) days. Applicable time-limits and other eligibility requirements are set forth in the Rhode Island Code of Regulations, Title 210, in the chapters related to each population Medicaid serves by eligibility coverage groups.

3. Cooperation. As a condition of eligibility, the Medicaid applicant/ beneficiary must meet certain cooperation requirements, such as providing the information needed for an eligibility determination, taking reasonable action to make income or resources available for support, assigning of rights to medical support or other third-party payments for medical care, or pursuing eligibility for other benefits. Failure to cooperate may result in a denial or termination of eligibility.

B. Eligibility Agent -- DHS. The Medicaid State Agency is authorized under Title XIX and federal implementing regulations to enter into agreements with other State agencies for the purposes of determining Medicaid eligibility. EOHHS has entered into a cooperative agreement with the Rhode Island Department of Human Services (DHS) that authorizes the DHS to conduct certain eligibility functions. In accordance with 42 C.F.R. § 431.10(e)(3), the DHS has agreed to

carry out these functions in accordance with the Medicaid State Plan, the State's Section 1115 demonstration waiver, and the rules promulgated by EOHHS.

C. Written Notice. EOHHS is responsible for notifying an applicant, in writing, of an eligibility determination. If eligibility has been denied, the notice to the applicant sets forth the reasons for the denial along with the applicable legal citations and the right to appeal and request a fair hearing. The Appeals Process and Procedures for EOHHS Agencies and Programs (Subchapter 05 Part 2 of this Chapter) regulations describe in greater detail the appeal and hearing process.

D. Mandatory Managed Care Service Delivery. To ensure that all Medicaid beneficiaries have access to quality and affordable health care, EOHHS is authorized to implement mandatory managed care delivery systems. Managed care is a health care delivery system that integrates an efficient financing mechanism with quality service delivery, provides a medical home to assure appropriate care and deter unnecessary services, and places emphasis on preventive and primary care. Managed care systems also include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the Medicaid agency. Managed care systems include the Medicaid program's integrated care options such as long-term services and supports and primary care health coverage for eligible beneficiaries. The managed care options for Medicaid beneficiaries vary on the basis of eligibility as follows:

1. Families with children eligible under the Part 30-00-1 of this Title are enrolled in a RIte Care managed care plan in accordance with the Part 30-05-2 of this Title or, as applicable, an employer health plan approved by EOHHS for the RIte Share Premium Assistance Program in accordance with the Part 30-05-3 of this Title unless specifically exempted;

2. Adults ages nineteen (19) to sixty-four (64) eligible in accordance with the Part 30-00-1 of this Title are enrolled in a Rhody Health Partners managed care plan in accordance with the Part 30-05-2 of this Title or, as applicable, an employer health plan approved by EOHHS for the RIte Share premium assistance program in accordance with the Part 30-05-3 of this Title unless specifically exempted;

3. Elders and adults who are blind or living with a disability and between the ages of nineteen (19) and sixty-four (64) eligible pursuant to Part 40-05-1 of this Title are enrolled in a Rhody Health Partners plan or Connect Care Choice primary care case management practices in accordance with Part 40-10-1 of this Title.

4. Persons eligible for Medicaid-funded long-term services and supports in accordance with the Part 50-00-1 of this Title have the choice of self-directed care, fee-for-service, or enrolling for services in PACE, Rhody

Health Options, or Connect Care Choice Community Partners in accordance with Part 40-10-1 of this Title.

5. Persons eligible as medically needy or as a result of participation in another publicly funded health and human services program may be enrolled in fee-for-service or a managed care plan depending on the basis of eligibility. See exemptions in the Part 30-05-2 of this Title "RIte Care Program" Parts 30-05-2 and 40-10-1 of this Title related to coverage group.

E. Waiver eligibility and services. Until 2009, the Medicaid program utilized authorities provided through its RIte Care Section 1115 and multiple Title 1915(c) waivers to expand eligibility and access to benefits beyond the scope provided for in the Medicaid State Plan. At that time, the State received approval from the Secretary of the U.S. Department of Health and Human Services (DHHS) to operate the Rhode Island Medicaid program under a single Section 1115 demonstration waiver. All Medicaid existing Section 1115 and Section 1915(c) waiver authorities have been incorporated into the Medicaid program-wide Section 1115 demonstration waiver, as it has been renewed and extended, since it was initially approved in 2009.

1.5 Program-wide Limits and Restrictions

A. Both federal and State law impose certain limits and restrictions on the scope, amount, and duration of the health care coverage, services, and supports financed and administered through the Medicaid program.

B. Benefits authorized under the Medicaid State Plan and the State's Sections 1115 demonstration waiver are limited as follows:

1. Organ Transplant Operations. Medicaid provides coverage for organ transplant operations deemed to be medically necessary upon prior approval by EOHHS.

a. Medical necessity for an organ transplant operation is determined on a case-by-case basis upon consideration of the medical indications and contraindications, progressive nature of the disease, existence of alternative therapies, life threatening nature of the disease, general state of health of the patient apart from the particular organ disease, any other relevant facts and circumstances related to the applicant and the particular transplant procedure.

b. Prior Written Approval of the Secretary or his/her designee is required for all covered organ transplant operations. Procedures for submitting a request for prior approval authorizations are available

through the provider portal on the EOHHS website at: www.eohhs.ri.gov/providers.

c. Authorized Transplant Operations provided as Medicaid services, upon prior approval, when certified by a medical specialist as medically necessary and proper evaluation is completed, as indicated, by the transplant facility as follows:

(1) Certification by medical specialist required -- kidney transplants, liver transplants, corneal transplants, and bone marrow transplants.

(2) Certification by an appropriate medical specialist and evaluation at the transplant facility - pancreas transplants, lung transplants, heart transplants, heart/lung transplants.

d. Other Organ Transplant Operations as may be designated by the Secretary of EOHHS after consultation with medical advisory staff or medical consultants.

2. Pharmacy Services for Dual Eligible Beneficiaries. Under federal law, states providing a Medicaid-funded pharmacy benefit must extend or restrict coverage and co-pays to beneficiaries eligible for both Medicaid and Medicare as follows:

a. Medicare Part D Wrap. Medicaid beneficiaries who receive Medicare Part A and/or Part B, qualify for Part D and must receive their pharmacy services through a Medicare-approved prescription drug plan. Therefore, these dually eligible Medicaid-Medicare beneficiaries are not eligible for the Medicaid pharmacy benefits. There are, however, certain classes of drugs that are not covered by Medicare Part D plans. Medicaid coverage is available to those receiving Medicare for these classes of drugs. The classes of drugs covered by Medicaid are: vitamins and minerals (with the exception of prenatal vitamins and fluoride treatment), Medicaid-approved over-the-counter medications, cough and cold medications, smoking cessation medications, and covered weight loss medications (with prior authorization). When purchasing these classes of drugs, Medicaid beneficiaries are required to pay a co-payment of one dollar ($1.00) for generic drug and three dollars ($3.00) for a brand name drug prescription.

b. Medicare Part D Cost-sharing Exemption. There is no Medicare Part D cost-sharing for full benefit Medicaid-Medicare dual eligible beneficiaries who would require the level of services provided in a long-term health facility if they were not receiving Medicaid-funded home and community-based services under Title XIX waiver

authority, the Medicaid State Plan, or through enrollment in a Medicaid managed care organization. To obtain the cost-sharing exemption, the Medicare Part D plan sponsor must receive proof of participation in one of the following Medicaid-funded home and community-based services programs: Preventive/Core Services, Personal Choice, Habilitation, Shared Living, and Assisted Living as well as the co-pay program administered by the Division of Elderly Affairs (DEA).

C. Federal law and regulations authorize the Medicaid agency or its authorized contractual agent (managed care plan/organization) to place appropriate restrictions on a Medicaid-funded benefit or service based on such criteria as medical necessity or on utilization control (42 C.F.R. § 440.230(d)). The Medicaid "Pharmacy Home" lock-in Program was established under this authority to restrict access to full pharmacy services in instances in which there is documented excessive use by a beneficiary. Beneficiaries are "locked-in" to specific providers in order to monitor services received and reduce unnecessary or inappropriate utilization. This program is intended to prevent Medicaid beneficiaries from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies. Additional information on the Pharmacy Home Lock-in Program is contained in Part 30-05-2 of this Title ("Managed Care Delivery Options").

1.6 Cooperation Requirements

A. As a condition of eligibility, the Medicaid applicant/ beneficiary must meet certain cooperation requirements, such as providing the information needed for an eligibility determination, taking reasonable action to make income or resources available for support, assigning of rights to medical support or other third-party payments for medical care, or pursuing eligibility for other benefits. Failure to cooperate may result in a denial of eligibility or case closure.

1.7 Direct Reimbursement to Beneficiaries

A. Some individuals, while appealing a determination of Medicaid ineligibility, incur and pay for covered services. Direct reimbursement may be available to beneficiaries in certain circumstances. Direct reimbursement is available to such individuals if, and only if, all of the following requirements are met:

1. A written request to appeal a denial or discontinuance of Medicaid coverage is received by the State within the time frame specified in the) "Appeals Process and Procedures for EOHHS Agencies and Programs" (Subchapter 05 Part 2 of this Chapter) regulations.

2. The original decision to deny or discontinue Medicaid coverage is reversed on appeal by the Appeals Officer or by the Regional Manager or Chief Supervisor/Supervisor).

3. Reimbursement is only available if the original decision was reversed. Reimbursement is not made, for example, if the original decision is reversed because information or documentation, not provided during the application period, is provided at the time of the appeal.

4. The beneficiary submits the following:

   a. A completed Application for Reimbursement form;

   b. A copy of the medical provider's bill or a written statement from the provider which includes the date and type of service;

   c. Proof of the date and amount of payment made to the provider by the beneficiary or a person legally responsible for the beneficiary. A cash receipt, a copy of a canceled check or bank debit statement, a copy of a paid medical bill, or a written statement from the medical provider may be used as proof of payment, provided the document includes the date and amount of the payment and indicates that payment was made to the medical provider by the beneficiary or a person legally responsible for the beneficiary.

5. Payment for the medical service was made during the period between a denial of Medicaid eligibility and a successful appeal of that denial. That is, payment was made on or after the date of the written notice of denial (or the effective date of Medicaid termination, if later) and before the date of the written decision issued by the EOHHS Appeals Office, or decision by the Regional Manager/Chief Casework Supervisor after, reversing such denial is implemented (or the date Medicaid eligibility is approved, if earlier).

1.8 Procedure and Notification

A. Notices of Medicaid ineligibility provide applicants and beneficiaries with information about their rights to appeal the agency's decision. These notices also contain specific information about the availability of direct reimbursement if a written appeal is filed and the State's initial decision is overturned as incorrect. The rules governing appeals and hearings are located in "Appeals Process and Procedures for EOHHS Agencies and Programs" (Subchapter 05 Part 2 of this Chapter) regulations.

B. The EOHHS Appeals Office must provide individuals who may qualify with an Application for Reimbursement form to request repayment for medical expenses which they incurred and paid while their appeal was pending.

C. The individual must complete and sign the Application for Reimbursement form and include:

   1. A copy of the provider's bill showing date and type of service; and

2. Proof that payment was made by the beneficiary or a person legally responsible for the beneficiary between the date of the erroneous denial and the date of the successful appeal decision. The completed form and required documentation is returned to the appropriate department representative.

D. If either the bill or proof of payment is not included with the Application form, the Medicaid agency representative offers to assist the beneficiary in obtaining the required documentation and sends a reminder notice requesting return of the required information within thirty (30) days from the date of receipt of the Application for Reimbursement form. If all documents are not received within thirty (30) days, or if the documentation provided indicates that medical service or payment was not made between the date of Medicaid denial (or termination) and the date of Medicaid acceptance (or reinstatement), the agency representative denies the request for reimbursement.

E. Otherwise, the agency representative forwards a referral form, attaching the beneficiary's written request for reimbursement and all supporting documentation to the Medicaid agency for a decision on payment. The Medicaid agency is responsible for providing the individual with written notification of the agency's decision and rights to appeal.

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