210-RICR-30-05-3

TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

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

SUBCHAPTER 05 – SERVICE DELIVERY OPTIONS

PART 3 – RIte Share Premium Assistance Program

3.1 Overview / Legal Authority

A. This Part is promulgated pursuant to Federal authorities as follows:

1. Federal Law: § 701(f)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1181(f)(3); § 1115 of the Social Security Act, 42 U.S.C. § 1315; Title XIX of the Social Security Act, 42 U.S.C §§ 1396a-1396w-8; Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa-1397mm; 42 U.S.C. § 1396k

2. The Medicaid State Plan and the Section 1115 Demonstration Wavier granted pursuant to § 1115 of the Social Security Act, 42 U.S.C. § 1315

B. Applicable State authority is derived from R.I. Gen. Laws Chapters 40-6, 42-7.2, 40-8, 40-8.4, 40-8.12, and 42-12.3.

3.2 Scope and Purpose

A. This Part applies to individuals determined to be Medicaid-eligible under Chapter 30 of this Title. If these individuals have access to employer sponsored insurance (ESI) and the employed person works thirty (30) or more hours per week, EOHHS must conduct a review of the coverage to determine if the benefits are comparable to Medicaid benefits and if the cost of the ESI is less expensive than Medicaid managed care (in the aggregate). When ESI is found to be cost-effective, the State will pay the employee's premium for that coverage as well as wrap-around costs such as deductibles, co-insurance, etc.

B. The purpose of this rule is to set forth the provisions governing participation in the RIte Share Program, the Buy-in requirement, and the process for determining whether an ESI plan meets the cost-effectiveness criteria established by EOHHS, the Medicaid agency. The rule also identifies the respective roles and responsibilities of Medicaid-eligible individuals and the Medicaid agency.

3.3 Incorporated Materials

A. These regulations hereby adopt and incorporate 42 CFR § 447.15 (2023) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these regulations.

3.4 Definitions

A. For the purposes of this section, the following definitions apply:

1. "Applicant" means a person seeking Medicaid coverage under this Part, in accordance with the provisions established in Rhode Island General Laws and Public Laws.

2. "Cost-effective" means that the portion of the ESI that the State would subsidize, as well as wrap-around costs, would, on average, cost less to the State than enrolling that same individual/family in a Medicaid managed care plan.

3. "Cost-sharing" means the amount of money the RIte Share Buy-in recipients must pay monthly for their monthly RIte Share coverage.

4. "Employee premium" means the monthly amount an individual or family is required to pay to the employer to obtain and maintain ESI coverage.

5. "Employer-sponsored insurance" or "ESI" means health insurance or a group health plan offered to employees by an employer. This includes plans purchased by small employers through HealthSource RI, the State's health insurance marketplace.

6. "Federal poverty level" or "FPL", as used herein, means the most recently published federal poverty level by the U.S. Department of Health and Human Services.

7. "Group health plan" means an employee benefits plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 as qualified in R.I. Gen. Laws §§ 27-50-3(t)(1) and 27-18.6-2(15).

8. "Health insurance coverage" or "Health benefit plan" means a policy, contract, certificate or agreement offered by a health insurance carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services as defined and qualified in R.I. Gen. Laws §§ 27-18.5-2(7), 27-18.6-2(14) and 27-50-3(u)(1).

9. "Medicaid member" means a person who has been determined to be eligible for Medicaid benefits.

10. "Modified Adjusted Gross Income" or "MAGI" means income, adjusted by any amount excluded from gross income under Section 911 of the IRS Code, and any interest accrued. Social Security benefits are not included in gross income. The MAGI methodology is the standard for determining income eligibility for all Medicaid affordable care coverage groups, which are described in further detail in Part 1 of this Chapter.

11. "Policy holder" means the employee with access to ESI.

12. "Rhode Island Works" or "RI Works" means the State's Temporary Assistance for Needy Families (TANF) program that provides assistance to low income needy families on the path to full employment and financial independence. The Program is administered by the Rhode Island Department of Human Services, one of the four State agencies under the Executive Office of Health and Human Services (EOHHS) umbrella.

13. "RIte Share-approved employer-sponsored insurance" means an ESI plan that meets the coverage and cost-effectiveness criteria for RIte Share.

14. "RIte Share Buy-In" means, the requirement that applies to a household with MAGI-based income above 150% of the FPL where only the child(ren) is Medicaid eligible and the parent/caretaker has access to ESI that is RIte Share-approved. These families are required to enroll in RIte Share, the State will pay the premium for a family plan, and the parent/caretaker will be responsible for a small monthly cost share to the State.

15. "RIte Share Premium Assistance Program" means the Rhode Island Medicaid premium assistance program in which the State pays the eligible Medicaid member's share of the cost of enrolling in a RIte Share-approved ESI plan. This allows the State to share the cost of the health insurance coverage with the employer.

16. "RIte Share Unit" means the entity within EOHHS responsible for assessing the cost-effectiveness of ESI, contacting employers about ESI as appropriate, initiating the RIte Share enrollment and disenrollment processes, handling member communications, and managing the overall operations of the RIte Share Program.

17. "Third-party liability" or "TPL" means other health insurance coverage. This insurance is in addition to Medicaid and is usually provided through an employer. Since Medicaid is always the payer of last resort, the TPL is always the primary coverage.

18. "Wrap-around services or coverage" means any health care services not included in the ESI plan that would have been covered had the Medicaid member been enrolled in a Medicaid managed care plan (see Part 2 of this Subchapter for details). Coverage of deductibles, co-insurance and

benefits covered by Medicaid but not the commercial plan are included in the wrap (co-payments to providers are not covered, however, pursuant to 42 CFR § 447.15, Medicaid enrolled providers must accept Medicaid payment as payment in full and cannot charge the member a co-pay).

3.5 RIte Share Populations

A. The income of Medicaid members affects whether and in what manner they must participate in RIte Share. RIte Share populations are determined pursuant to R.I. Gen. Laws § 40-8.4-12(c).

1. RIte Share includes: children, parents and caretakers, and individuals who are pregnant, who are eligible for Medicaid, or the Children's Health Insurance Program (CHIP), and childless adults between the ages of nineteen (19) and sixty-four (64) who are not receiving or eligible to receive Medicare but are Medicaid-eligible.

3.6 RIte Share Enrollment as a Condition of Eligibility

A. Medicaid members over the age of nineteen (19), who have access to RIte Share-approved ESI must enroll in that ESI as a condition of continuing Medicaid eligibility. This requirement also applies to any individuals who have, or previously have had the option to waive ESI coverage to receive financial compensation, including but not limited to, an increase in hourly wage, an increase in weekly salary, and/or a lump sum payment. (An increase in wages for waiving coverage is also known as "pay in lieu of benefits.")

1. Mandatory ESI Enrollment – Once EOHHS has determined that the ESI offered by a particular employer is RIte-Share-approved, all eligible Medicaid members with access to that ESI are required to enroll in that coverage.

a. Failure to meet the mandatory enrollment requirement results in the termination of the Medicaid eligiblity of the policy holder and other Medicaid members nineteen (19) or older in the household who would have been covered under the ESI. These individuals will remain terminated until the policy holder complies with the RIte Share participation and enrollment procedures established in § 3.18 of this Part.

b. Children under age nineteen (19) will not be sanctioned if the policy holder does not comply and, instead, will remain/be enrolled in Medicaid managed care.

c. Pregnant individuals in the household will not be sanctioned if the policy holder does not comply and instead will remain/be enrolled in Medicaid managed care.

d. Individuals enrolled in RI Works (TANF) are exempt from the mandatory enrollment requirement for the first six (6) months of employment. See § 3.7 of this Part below.

2. Reinstatement – The period of ineligibility may be shortened and Medicaid eligibility reinstated if:

a. the policy holder complies with RIte Share's request to enroll in ESI;

b. the employer's plan is no longer RIte Share-approved; or

c. the policy holder no longer has access to that ESI (e.g., left employment, decrease in work hours, etc.).

3.7 RI Works Participants (TANF)

A. RI Works (TANF) participants who are Medicaid-eligible are not required to enroll in a RIte Share plan for their first six (6) months of employment. This six-month exemption also applies to families losing eligibility for RI Works due to employment. Specifically, to be subject to enrollment in a RIte Share approved ESI plan, the RI Works participant must be:

1. Age nineteen (19) or older; and

2. Employed for a period of six (6) consecutive months or more by the same employer.

B. RI Works participants who do not meet both of these criteria at the time Medicaid eligibility is renewed in accordance with § 3.15 of this Part are exempt from mandatory participation in RIte Share.

3.8 RIte Share Premium Assistance Payments

A. Under the RIte Share Premium Assistance Program, the State pays the employee's share of their ESI premium and provides wrap-around coverage under Medicaid fee-for-service.

1. For the majority of those enrolled in RIte Share, EOHHS pays the employee directly for their share of the ESI prior to the anticipated date on which the premium is deducted from the employee's paycheck. The RIte Share Unit or its agent mails a check or electronically transfers payment to the policy holder, on a monthly basis, to cover the premium cost deducted from the policy holder's check.

2. For a limited number of those enrolled in RIte Share, the State pays the employer directly for the employee's share of the premium, thereby foregoing the need to deduct the premium from the employee's paycheck.

This payment method is limited to employers who have been grandfathered into this option.

B. Cost-sharing – With the exception of the Buy-In Program (see § 3.9), Medicaid members enrolled in ESI are not obligated to pay any cost-sharing that is not otherwise applicable to Medicaid.

C. Wrap-around coverage – This includes deductibles, co-insurance and services and benefits that are covered by Medicaid, but are not offered through the ESI plan. Wrap-around coverage is only available for services provided by Medicaid enrolled providers.

4. Repayment and recoupment – EOHHS has the authority to recover Medicaid benefit overpayment claims and cost-share arrearages through offset of the individual State income tax refund in accordance with R.I. Gen. Laws §§ 44-30.1-1, 44-30.1-3, 44-30.1-4 and 44-30.1-8 in R.I. Gen. Laws Chapter 44-30.1 entitled 'Setoff of Refund of Personal Income Tax.'

3.9 RIte Share Buy-in Requirement

A. In certain instances, Medicaid members participating in RIte Share are subject to a Buy-in requirement. This requirement applies to a household with MAGI-based income above 150% of the FPL where only the child(ren) is Medicaid eligible, and the parent/caretaker has access to ESI that is RIte Share-approved.

1. Buy-in amount – The parent/caretaker is required to pay a monthly Buy-in amount that varies with income as follows:

Monthly Family Income	Monthly Buy-In Amount
Over 150% and not greater than 185% FPL	$ 61.00
Over 185% and not greater than 200% FPL	$ 77.00
Over 200% and not greater than 250% FPL	$ 92.00

2. Notice – EOHHS must provide the adult in the family subject to the Buy-in requirement with timely notice. This may be done separately or in conjunction with the notice of RIte Share participation. The notice must include the amount of the buy-in, the process for making payments, the consequences for non-payment and a statement of the right to appeal and request a hearing.

3. Payment – Buy-in amounts are not prorated. Therefore, a full monthly Buy-in amount is due if RIte Share enrollment is effective for any portion of a coverage month.

4. Method of payment – EOHHS deducts the Buy-in amount from the State's premium payment to the member. For the limited number of RIte Share members described in § 3.8(A)(2), the member receives an invoice and pays the state directly.

5. Non-compliance – Individuals subject to the buy-in requirements must cooperate in making monthly Buy-in payments in accordance with § 3.8 of this Part to remain enrolled in ESI. Failure to make a required premium payment for three consecutive months will result in Medicaid termination of all adults enrolled in RIte Share. Children will be transitioned to managed care.

3.10 Basis for Approving ESI Plans

A. Only ESI or group health plans that meet the cost-effectiveness and benefits criteria specified in this Part are approved for the RIte Share Premium Assistance Program.

1. Sources of information for determining cost-effectiveness – Determinations of ESI cost-effectiveness are based on information gathered from the following sources:

a. Application materials. When applying for Medicaid, applicants must indicate: current health insurance coverage status; relationship to policy holder; plan name; policy number. Subchapter 00 Part 3 of this Chapter explains the process for applying for Medicaid through the State's affordable care eligibility system and the manner in which this information is collected and maintained.

b. The RIte Share Unit. This EOHHS unit collects employer data from the Medicaid member, employer, broker and/or insurance carrier about the ESI plans offered by the employer. Information includes rates and benefit summaries which are necessary to determine whether the employer's ESI meets EOHHS's cost-effectiveness criteria.

2. EOHHS reserves the right to request additional information about the ESI from the Medicaid member, the policy holder (even if the policy holder is not Medicaid-eligible), the employer, broker and/or insurance carrier.

3.11 Methodology for Determining Cost-Effectiveness

A. The RIte Share Unit uses the information about the ESI to compare the cost of the employee's share of the ESI, as well as wrap-around costs, to the cost of enrollment in Medicaid managed care. An ESI plan is determined to be cost-effective when, on the aggregate, the total cost of medical coverage through RIte Share is less than the cost of coverage if enrolled in a Medicaid managed care

plan. RIte Share participants receive coverage comparable in scope, amount, and duration to coverage provided in a Medicaid managed care plan.

1. Cost-effectiveness test – To be cost-effective, the policy holder's monthly ESI premium share, deductibles, co-insurance, plus any Medicaid covered services not covered by the ESI plan (such as services covered under the managed care contracts, but not under the ESI plan), must be less than the average capitation payment for a member enrolled in a Medicaid managed care plan. These average costs must be actuarially determined at such intervals as deemed appropriate by EOHHS.

2. The analysis of cost effectiveness is dependent on the Medicaid eligibility status of each member of the household. Cost effectiveness determinations will be based on one of the following scenarios as applicable:

    a. Household in which all individuals are Medicaid-eligible;

    b. Household in which only child(ren) and/or pregnant women in the family are Medicaid-eligible;

    c. Household in which childless adult is Medicaid-eligible; or

B. The figures used as the basis for assessing cost-effectiveness shall be made available, upon request, by EOHHS.

3.12 Scope and Consequence of Approving an ESI Plan

RIte Share-approved ESI plans need to be reevaluated on an annual basis, in alignment with annual renewals of employer insurance, to ensure that the ESI remains cost-effective. From the date an ESI plan is approved until the date it is reevaluated, any Medicaid members who work for that employer, and their Medicaid-eligible dependents, must enroll in the ESI through RIte Share.

3.13 Member Enrollment Process

A. Medicaid members who are required to participate in RIte Share must enroll in the ESI plan as directed by EOHHS. Enrollment into RIte Share may occur upon initial determination or at the time of Medicaid annual renewal, or as deemed appropriate by EOHHS. Enrollment in RIte Share is considered to be a "qualifying event" and may occur at any time, including outside of the employer's open enrollment period. Additionally, according to section 701(f)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1181(f)(3), a group health plan must permit an employee (or dependent) who is:

1 eligible for but not enrolled in the ESI, and

2 determined eligible for an ESI premium assistance program under Medicaid or CHIP, to enroll in ESI coverage no later than 60 days after the date the employee (or dependent) is determined eligible for the premium assistance program.

3. Eligibility determination and RIte Share referral – The referral for RIte Share participation is based on employment information provided by the Medicaid member, as well as information available about the employer's ESI offering (i.e. whether the employer offers RIte Share-approved coverage).

4. Notice of RIte Share requirement:

   a. Upon determining that a Medicaid member is eligible for RIte Share, EOHHS sends a "Go Enroll" letter stating the employee must enroll in a RIte Share-approved ESI plan through their employer's personnel or human resources office within fourteen (14) calendar days of the date on which the letter was generated.

   b. If no response is received, a second letter is sent.

   c. If no response is received thirty (30) days after the initial "Go Enroll" letter was sent, a sanction notice is generated informing the adults in the household that they will lose Medicaid eligiblity and their children will remain/be enrolled in managed care.

3.14 Continuing Eligibility – Medicaid Renewals

A. For Medicaid members renewing eligibility, EOHHS must assess as part of the redetermination process whether anyone in the household is a RIte Share participant and if there has been any change in access to ESI.

1. Notice of renewal – Medicaid members must be provided with a notice at the time of renewal specifying the terms for continuing eligibility. The terms for continuing coverage vary as follows:

   a. Medicaid managed care enrollees without access to ESI continue enrollment in the Medicaid managed care plan that provided coverage in the previous period of eligibility in accordance with Part 2 of this Subchapter.

   b. Medicaid managed care enrollees who have gained access to a RIte Share-approved ESI plan continue to be enrolled in the Medicaid managed care plan that provided coverage in the previous period of eligibility pending review by the RIte Share Unit.

   c. RIte Share participants who retain access to the RIte Share-approved ESI plan that provided coverage during the during the

previous period of eligibility, continue to be enrolled in the ESI plan pending review by the RIte Share Unit of any changes that might result in withdrawal of approval of the ESI plan, disenrollment, and subsequent enrollment in a Medicaid managed care plan.

2. Loss of ESI – RIte Share participants who involuntarily lose access to an approved ESI plan that provided coverage during the previous period of eligibility for any of the reasons stated in § 3.19 of this Part receive coverage as follows:

   a. Any Medicaid-eligible individuals in the family will receive coverage through fee-for-service pending either enrollment in a Medicaid managed care plan, or if the Medicaid member gained access to another ESI plan, approval of that plan by the RIte Share Unit.

3. Notice of renewal – In all such cases, the notice of renewal for continuing eligibility sent by EOHHS to the Medicaid members shall include a statement of the applicable terms for continuing eligibility including any Buy-in requirement, the reason(s) for establishing the terms, and the right to appeal and request a hearing with respect to either (See Part 10-05-2 of this Title), as well as all other information required in this section. The enrollment referral transmitted to the RIte Share Unit shall also indicate which terms apply and shall be sent at the time the redetermination is made.

3.15 Renewal of RI Works Participants (TANF)

A. At the time eligibility renewals are completed, EOHHS is responsible for assessing whether RI Works participants are subject to enroll in a RIte Share-approved plan as a condition of continuing Medicaid eligibility.

1. Employed under six (6) months – Only those RI Works participants, age nineteen (19) or older, who have access to ESI and have been steadily employed for a period of six (6) consecutive months or more, shall be subject to enrollment in RIte Share. All other RI Works participants continue enrollment in the Medicaid managed care plan which provided coverage until the next scheduled redetermination of eligibility.

2. Employed six (6) months or over – If the RI Works participant has been employed for over six (6) months, the notice of renewal sent by EOHHS must state that enrollment in the Medicaid managed care plan that provided coverage during the previous period of eligibility is continued, pending review of the ESI plan by the RIte Share Unit. If enrollment in an approved ESI plan is a condition of retaining continuing eligibility, Medicaid members shall receive notice from the RIte Share Unit at least fourteen (14) days prior to enrollment in an ESI plan.

3.16 Role of RIte Share Unit

A. The RIte Share Unit is responsible for overseeing the operations of the program as follows:

1. Gathering information from employers and employees about the health plans they offer to workers on an ongoing basis;

2. Evaluating health plans for RIte Share approval;

3. Entering cost-effective information into the RI Bridges system; and

4. Contacting employers and employees to make RIte Share enrollment decisions.

B. Upon receipt of member referral information, the RIte Share Unit verifies employment and access to a RIte Share-approved ESI plan. Based on this review, the RIte Share Unit determines:

1. Whether the Medicaid member is approved for RIte Share; and

2. The date that individual or family must enroll in the ESI in order to maintain Medicaid eligibility.

C. The specific procedures for making such determinations vary depending on the enrollment status of the Medicaid member and the employer's customary enrollment process.

3.17 ESI Enrollment Verification

A. Verification of enrollment in a RIte Share-approved ESI plan is required.

1. For Medicaid members working for an employer who offers RIte Share approved coverage, the employer is required to submit verification to the RIte Share Unit that initial enrollment in the ESI has been made in the manner prescribed by EOHHS.

2. The individual or employer must submit verification of enrollment by completing the Employer Verification form, which requires the signature of both a representative of the employer and the member.

3.18 Failure to Enroll

A. Failure to enroll in the ESI plan is grounds for termination of Medicaid eligibility for the non-pregnant parent(s) or caretaker over the age of nineteen (19) in the household who would have been enrolled in RIte Share (see § 3.6 of this Part for details).

1. Discontinuation – EOHHS sends an "Ineligible for Medicaid Notice", stating that Medicaid eligibility has been terminated for adults in the household due to the failure to enroll in the RIte Share-approved plan. Anyone in the household subject to the notice may reapply (for inactive cases) or request reinstatement (for active Medicaid cases) if:

    a. they choose to comply with RIte Share;

    b. an exemption from participation is granted; or

    c. the individual no longer has access to the ESI.

B. The "Ineligible for Medicaid Notice" shall include a statement indicating that any affected Medicaid-eligible individuals in the household have the right to appeal and to request a hearing to contest the change in eligibility and the enrollment decision.

3.19 Disenrollment from RIte Share-Approved Plan

A. Pursuant to Part 30-00-3 of this Title, RIte Share members who are voluntarily or involuntarily disenrolled from an approved ESI plan must report the change in enrollment status to EOHHS in no more than ten (10) days from the date the disenrollment action occurs. The type of disenrollment will determine EOHHS's action as follows:

1. Voluntary disenrollment – Medicaid-eligible RIte Share members age nineteen (19) or older who voluntarily disenroll from an approved ESI will be terminated for coverage based on the failure to meet the non-financial cooperation requirements set forth in this Part. Voluntary disenrollment includes, but is not limited to, instances in which a RIte Share member:

    a. Requests that the employer drop coverage or cease enrollment for the entire family or a Medicaid-eligible individual in the family;

    b. Fails to meet the requirements established by the employer to maintain enrollment in the approved plan such as, submit required documentation or forms.

    c. Engages in unlawful or fraudulent acts, such as submitting false claims that violate the terms for continuing enrollment in the ESI plan. Please refer to § 3.6 of this Part.

2. Involuntary disenrollment – Involuntary disenrollment includes the loss of access to ESI as a result of change in employment, termination of coverage by the employer for an entire class of workers, death, separation, divorce, disability of the policy holder, or any other factors that

could be reasonably construed as involuntary disenrollment as defined in this Part.

3. RIte Share Unit responsibilities – Upon receiving a report from the employer, broker and/or the insurance provider, or Medicaid member indicating that disenrollment has occurred, the RIte Share Unit verifies the accuracy of the report and assesses whether it is voluntary or involuntary in nature.

   a. Voluntary Disenrollment – Once the report has been verified and it is determined to be voluntary disenrollment, EOHHS sends a "Ineligible for Medicaid Notice" noting termination of the Medicaid eligibility of the policy holder, parent(s) or caretaker relative in the applicant's household until the individual demonstrates compliance with enrollment procedures established by EOHHS. The "Ineligible for Medicaid Notice" must also include any remedies for shortening the period of ineligibility as well as the right to request a hearing and appeal the decision:

      (1) All Medicaid-eligible pregnant women and children must be automatically enrolled in a Medicaid managed care plan.

      (3) This period of Medicaid ineligibility may be shortened and Medicaid eligibility established if such individual complies, becomes exempt from RIte Share enrollment, or no longer has access to ESI for reasons such as a change in employment. (See § 3.18 of this Part).

   b. Involuntary disenrollment – There is no adverse action taken against Medicaid members required to participate in RIte Share if disenrollment from an approved ESI plan is involuntary.

3.20 Cooperation Requirements

A. All Medicaid applicants and members must cooperate with the non-financial requirements for eligibility as follows:

1. Requirement to provide information – All applicants/members are required to provide information about other health coverage they may have (TPL – Third Party Liability) including:

   a. The names of any family members in the household currently covered by other insurance;

   b. The name of the policy holder and the employer offering the insurance coverage; and

c. When requested, verification of monthly enrollment costs via a paycheck stub if the policy holder is currently enrolled or, if available, enrollment information provided by the employer indicating the policy holder's monthly premium for the appropriate family composition.

2. Requirement to enroll in ESI – Medicaid members required to enroll in the ESI must cooperate as follows:

a. Enroll in the ESI in the manner, and within the timelines, established by EOHHS. Failure to do so will result in the termination of Medicaid for any eligible parents/caretaker age nineteen (19) and older in the family who would otherwise have been enrolled in RIte Share. Children and/or individuals who are pregnant will not be terminated from Medicaid. See § 3.18 of this Part.

b. Submit verification of enrollment in accordance with § 3.17 of this Part when the employer does not participate in RIte Share.

c. Provide reports to EOHHS indicating any changes in enrollment status of Medicaid-eligible family members, enrollment costs, household composition, employment, income, residence, and access to ESI within ten (10) days from the date the change occurs.

3. Requirement to notify both DHS and EOHHS of loss of employment – Pursuant to Part 30-00-3 of this Title, Medicaid members must notify the State that they are no longer employed or no longer have access to ESI so that payment can be stopped. Payments are NOT transferrable from one employer to another (i.e., payment is employer-specific). If a member receives payment for coverage for which they are no longer eligible, they will be responsible for paying those premiums back to EOHHS. Pursuant to Part 10-00-6 of this Title, If a member does not pay back those overpayments, the State has a right to recoup those dollars from the member's RI tax refund (see § 3.8).

3.21 Good Cause

A. EOHHS is responsible for determining whether good cause exists for an exception to the non-financial cooperation requirements for Medicaid eligibility contained in Subchapter 00 Part 1 of this Chapter and, more specifically, for participation in RIte Share, except as noted below:

1. Extraordinary circumstances – EOHHS must exempt a Medicaid member from RIte Share participation only when there are extraordinary circumstances which preclude the individual from receiving medically necessary care through the RIte Share-approved plan. For purposes of

this exemption, "extraordinary circumstances" may include but not be limited to:

a. The existence of an unusual and life-threatening medical condition which requires medical treatment that cannot be provided or arranged by the ESI plan;

b. The existence of a chronic, severe medical condition for which the Medicaid member has a long-standing treatment relationship for that condition with a provider who does not participate in the ESI plan and/or refuses to enroll as a Medicaid participating provider.

3. Other programs – If good cause has been granted for any other benefit program administered by EOHHS or DHS, the good cause exemption will be honored by the RIte Share Program.

4. Nature of request – Enrollment exemptions requested due to extraordinary circumstances must be in writing, with appropriate documentation (letter from physician, medical records, restraining orders, or others as indicated), and signed by the Medicaid member, parent/caretaker or person designated to make the request on their behalf.

5. Basis of the determination – EOHHS makes RIte Share participation exemption determinations on a case-by-case basis after considering all required documentation and any other relevant information pertaining to the request. An exemption may be granted for any length of time during the period in which the extraordinary circumstances exist. When an exemption is granted, Medicaid member is enrolled in the appropriate Medicaid managed care plan in accordance with Part 2 of this Subchapter.

6. Limits – An individual's preference to continue a treatment relationship with a doctor or other health care provider who does not participate in the RIte Share plan or Medicaid program does not in and of itself constitute an "extraordinary circumstance."

3.22 Notice and Appeal Rights

Medicaid applicants and recipients shall receive timely notification of eligibility and enrollment determinations and the right to appeal. EOHHS shall also provide timely notification, including appeal rights, of any adverse decisions that reduce or terminate benefits. See Part 10-05-2 of this Title for full statement of these rights.

3.23 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.

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