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Title 210 - Executive Office of Health and Human Services

Chapter 40 - Medicaid Integrated Health Care Coverage

Subchapter 00 – N/A

Part 1 – Overview of Medicaid Integrated Care Coverage

1.1 Overview of this Chapter

A. This chapter establishes the Medicaid "Integrated Health Care Coverage (IHCC)" groups for elders, adults with disabilities, and certain individuals who qualify as medically needy (MN) due to high health care expenses. In addition, sections of this chapter set forth the basic tenets of the SSI methodology for determining Medicaid eligibility in general and, specifically, for those applicants and beneficiaries seeking coverage through an IHCC Community Medicaid eligibility pathway. The term Community Medicaid refers hereinafter to anyone applying for or renewing eligibility for non-LTSS Medicaid health coverage as MN or through a pathway for elders and adults with disabilities on the basis of Supplemental Security Income (SSI), an SSI-related characteristic (that is, age, blindness or disabling impairment), or special requirements related to a particular characteristic, condition or circumstances. Community Medicaid also encompasses Medicare beneficiaries seeking financial assistance through the State's Medicare Premium Payment Program (MPPP). Although all the IHCC groups for MN and elders and adults with disabilities are described in this chapter – both Community Medicaid and LTSS, there are separate sections, as indicated below, that provide more in-depth provisions related to IHCC groups, as follows:

   1. The Sherlock Plan provides an eligibility pathway for adults with disabilities who are working. Although referenced in this section as one of the IHCC groups subject to the SSI methodology, the Sherlock Plan is covered in detail in a separate section (Medicaid Code of Administrative Rules, Sherlock Plan Regulations) along with other eligibility opportunities for persons with disabilities who are working.

2. An overview of the LTSS coverage groups subject to the SSI methodology is included in this chapter to show areas of overlap in the application process and determination of financial eligibility.

3. Children and families in the IHCC category who are eligible on the basis of their participation in other programs – e.g., children in foster care or SSI-eligible -- are addressed in the Medicaid Code of Administrative Rules, Medicaid Coverage for Children and Families.

1.2 Authority

This chapter of rules entitled, “Medicaid Code of Administrative Rules: “Medicaid Integrated Health Care Coverage (IHCC)” is promulgated pursuant to the authority set forth in R.I. Gen. Laws Chapters 40-8 (Medical Assistance); Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); and the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15).

1.3 Scope and Purpose

A. This section provides an overview of the IHCC groups included in this chapter. The rules governing the IHCC groups have been amended and revised as set forth herein to reflect programmatic changes resulting from the following State and federal Medicaid initiatives:

1. Extension of Rhode Island’s Section 1115 demonstration waiver – In December 2013, the State’s Section 1115 demonstration waiver was reauthorized and extended until 2018. The rules in this chapter implement Section 1115 waiver authorities that streamline and refine SSI-based eligibility determinations, enhance the availability of cost-effective primary care, and improve the integration of services and a wider range of supports across the care continuum.

2. ACA Implementation – The federal Affordable Care Act of 2010 mandated changes in the way states organize Medicaid coverage groups, the standards they use for determining income-based eligibility, and the application and renewal processes for all eligible populations. This chapter establishes administrative rules that implement ACA reforms related to eligibility and the application and renewal process for the IHCC groups to

ensure they match those already in effect for MACC groups subject to the MAGI.

3. Integrated Eligibility System --– “RI Bridges” is the State’s new integrated health and human services eligibility system (IES) launched in September 2016. The State’s IES provides the State with the system capacity to implement all programmatic changes required by the ACA and authorized under the Section 1115 waiver. In addition to automating most facets of the application, eligibility determination and enrollment processes, the State’s IES also conducts a multi-tiered evaluation of eligibility that makes it possible to consider applicants for most forms of publicly financed health coverage and various other State-administered health and human services through a single application process.

1.4 Definitions

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

1. “Affordable Care Act (ACA)” means The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).

2. “Applicant” means the person in the household who, if determined eligible, would qualify for Medicaid in one of the Integrated Health Care Coverage groups on the basis of the provisions set forth herein.

3. “Calendar quarter” means a period of three full calendar months beginning with January, April, July, or October.

4. “Community Medicaid” means the term used to refer to IHCC groups that are provided with Medicaid health coverage for essential primary care and limited preventive services in some circumstances, but does not include more than thirty (30) days of continuous LTSS.

5. “Executive Office of Health and Human Services (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.

6. “Dual Eligible Beneficiary” means a person who is enrolled in Medicaid and Medicare. The term includes elders and adults with disabilities who are enrolled in Medicare and receive Medicaid health coverage and/or financial assistance through the State’s Medicare Premium Payment Program (MPPP).

7. “Income Standard” means the maximum amount of countable income a person can have for Medicaid health coverage through an eligibility pathway or coverage group subsequent to all required exclusions, disregards, and deductions. Also referred to as the “income limit.”

8. “Long-Term Services and Supports (LTSS)" means a spectrum of services covered by the Rhode Island Medicaid program for persons with clinical and functional impairments and/or chronic illness that require the level of care typically provided in a health care institution. Medicaid LTSS includes skilled or custodial nursing facility care, therapeutic day services, and personal care as well as various home and community-based services. Medicaid beneficiaries eligible for LTSS are also provided with primary care essential benefits.

9. “Managed Care Arrangement (MCA)” means a system, often a managed care organization (MCO) that uses capitated financing to deliver high quality services and promote healthy 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. Section § 1.5 of this Part identifies the Medicaid managed care arrangements that serve IHCC elders, adults with disabilities and beneficiaries requiring LTSS; Medicaid Code of Administrative Rules Sections: RIte Care, Rhody Health Program, Enrollment, RIte Share Program, and Communities of Care pertain to managed Medicaid delivery systems for the MACC populations without regard to the basis for eligibility – MAGI, SSI, special requirements, etc.

10. “Medicaid Affordable Care Coverage (MACC) Groups” means the populations whose income eligibility for Medicaid is determined on the basis of the Modified Adjusted Gross Income (MAGI) standard. Includes children up to age 19, parents/caretakers, pregnant women, and otherwise ineligible adults 19 to 64 in accordance with the provisions established in

the Medicaid Code of Administrative Rules, Overview of the Affordable Care Coverage Groups.

11. “Medicaid Code of Administrative Rules (MCAR)” means the collection of administrative rules governing the Medicaid program in Rhode Island.

12. “Primary Care Essential Benefits” means non-LTSS Medicaid health coverage, and includes an array of acute, subacute, and specialty essential benefits, as identified under the Medicaid State Plan, provided by licensed health professionals. These essential benefits include, but are 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 visits, inpatient, home care, day care, etc.).

13. “Primary Care Provider” means a health care practitioner who is licensed as:

    a. a physician with a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine and is responsible for monitoring a beneficiary’s overall health; or

    b. a nurse practitioner, clinical nurse specialist, or physician assistant and, to the extent licensure allows, is responsible for, or collaborates with a physician, monitoring a beneficiary’s overall health.

14. “Resource Standard” means the maximum amount of resources a person can have for Medicaid health coverage through an eligibility pathway or coverage group subsequent to the application of all required exclusions. Also referred to as the “resource limit.”

15. “Wrap-around Coverage” means the Medicaid benefits provided to a beneficiary who has another form of health insurance – e.g., Medicare or commercial plan – that serves as the principal payer for his or her health care, but that does not cover those benefits.

1.5 IHCC Groups Subject to the SSI Methodology

A. On and after the effective date of this rule, the provisions of this chapter govern the following eligibility pathways that use the SSI methodology in whole or in part to determine eligibility for Medicaid benefits:

1. Elders and Adults with Disabilities (EAD) – Low-income elders who are sixty-five (65) and older and people living with disabilities who have income at or below one hundred percent (100%) of the Federal Poverty Limit (FPL) and resources at or under $4,000 for an individual or $6,000 for a couple.

2. Medically Needy (MN) – Elders, persons with disabilities, children, parents and caretakers of Medicaid-eligible children, and pregnant women who do not qualify for eligibility on the basis of income but have high health expenses and must spend or contribute income and/or resources above the applicable income eligibility standards to obtain or retain Medicaid eligibility. Subchapter 5 Part 1 of this Chapter pertains to the MN eligibility pathway for Community Medicaid.

3. Supplemental Security Income (SSI) Recipients – All persons receiving SSI cash assistance based on age or as an adult with a disability, as determined by the federal Social Security Administration (SSA). SSI recipients are automatically eligible for Medicaid on this basis and are not required to apply for Medicaid health coverage through the State. Program-specific provisions for SSI recipients twenty-one (21) and older are included in this chapter. The relevant provisions for Medicaid beneficiaries under 21 are located in the sections pertaining to coverage for children and families in Medicaid Code of Administrative Rules, Medicaid Coverage for Children and Families.

4. State Supplement Payment (SSP) – Persons who qualify to receive the optional state- funded supplemental payment are automatically eligible for Medicaid health coverage under the Medicaid State Plan. This group includes beneficiaries eligible on the basis of SSI and EAD as well those with higher income who require Medicaid LTSS who meet the special living arrangement requirements for SSP set by the State.

5. SSI Protected Status Beneficiaries – This group – sometimes referred to "SSI- lookalikes" – includes persons who meet the age or disability criteria for SSI, but are -- or become -- ineligible for full SSI cash benefits or qualify for special treatment. To protect Medicaid health coverage for members of these coverage groups, federal law requires the application of special rules that confer or preserve Medicaid eligibility.

6. Medicaid Premium Payment Program (MPPP) for Medicare beneficiaries with income at or below 135% of the FPL. The MPPP provides financial help through Medicaid to assist in paying Medicare costs including premiums, deductibles, and coinsurance in amounts that vary depending on income and resources.

7. Sherlock Plan for Working Adults with Disabilities – The State's program for working adults with disabilities. The Sherlock Plan provides Medicaid health coverage and/or services and supports to persons with disabilities who are working, and who otherwise meet the SSI disability criteria for Community Medicaid or, based on a functional and health status review, have the level of need required for Medicaid LTSS. As is set forth in greater detail in Medicaid Code of Administrative Rules, Sherlock Program Regulations, beneficiaries in this group may have countable income at or below two-hundred and fifty percent (250%) of the FPL and resources less than or equal to $10,000 individual and $20,000 for a couple.

8. IHCC Medicaid LTSS -- Consists of new applicants seeking Medicaid-funded LTSS and current IHCC group beneficiaries who develop a continuous need for the level of care typically provided in an institution (hospital, nursing facility, intermediate care facility for person with intellectual disabilities). Beneficiaries eligible in the MACC groups (see Medicaid Code of Administrative Rules, Overview of the Affordable Care Coverage Groups) who require LTSS are not subject to the SSI methodology; LTSS eligibility based on the SSI methodology and more generally is located in Medicaid Code of Administrative Rules, Evaluation of Resources and Resource Transfers.

1.6 IHCC Special Coverage Groups

A. The IHCC category also includes members of the special coverage groups below who are subject to unique eligibility requirements waiving some or all facets of the SSI methodology due to specific conditions, circumstances or characteristics.

1. Low-income, uninsured women with breast or cervical cancer – Medicaid coverage group for uninsured women under age sixty-five (65) who are screened under the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and are found to need treatment for breast or cervical cancer or for precancerous conditions of the breast or cervix.

2. Refugee Medicaid Assistance (RMA) – Federally mandated coverage group for individuals and families operating under the auspices of the U.S. Department of Health and Human Services, Office of Refugee Resettlement. Refugees who qualify for this program receive eight (8) months of Medicaid health coverage or commercial coverage with financial help through HSRI, depending on income. Eligibility is evaluated first using the MAGI methodology set forth in Medicaid Code of Administrative Rules, Overview of the Affordable Care Coverage Groups, and the SSI standards for Community Medicaid in § 05-1.11.1 of this Chapter. Only persons in this group who are ineligible for Medicaid or commercial plan with financial help and have income at or below 200 percent of the FPL may qualify for MN coverage under this chapter.

3. Emergency Medicaid – Medicaid health coverage available to non-citizens who have emergency health care needs who meet all the general and income requirements for coverage with the exception of immigration status.

1.7 The State's Integrated Eligibility System (IES)

A. With the implementation of the State's IES, all IHCC group members have the option of applying on-line, using a self-service portal, submitting a completed paper application, or in-person by visiting one of the field offices of the RI Department of Human Services (DHS). The IES also allows for the following important changes to the application and eligibility determination process:

1. Coverage Group Options – To maximize choice and ease of access, the State's IES evaluates all applicants for Medicaid health coverage using multiple eligibility pathways, within and across the major coverage group categories.

2. Streamlined Document Submission and Verification – The State's IES created the capacity for applicants and beneficiaries to upload important documents and verification materials on-line as well through more traditional means. The State is also building into the system access to a broader array of electronic data sources for verifying and updating critical eligibility information related to income and assets.

3. Modified Passive Eligibility Renewal – The eligibility renewal process for IHCC group members has been reformed to ease the burden on beneficiaries. The State's new passive renewal process requires beneficiaries to review the eligibility information in their accounts, including updates through electronic data sources, and notify the agency within a specified time period of any changes or discrepancies that may affect the continuation of coverage. The renewal process and variations across coverage groups are set forth in Part 2 of this Subchapter.

1.8 Medicaid Benefits

A. The benefits that members of the IHCC groups receive are dictated by the Medicaid State Plan and the State's Section 1115 demonstration waiver. Medicaid benefits include health care services and supports or, if a beneficiary has third party coverage such as Medicare, wrap-around coverage and/or financial assistance in paying premiums, co-pays, and cost-sharing.

1. Premium Assistance/and Financial Help – Dual Medicare and Medicaid beneficiaries, including those participating in the MPPP may receive full Medicaid health coverage and/or financial help paying for Medicare. The scope of benefits dual eligible beneficiaries receive depends on their income and resources. Premium assistance is also available for some Community Medicaid beneficiaries who have access to employer-sponsored insurance through the RIte Share Premium Assistance Program as set forth in Medicaid Code of Administrative Rules, Overview of the Affordable Care Coverage Groups.

2. Health Care Services and Supports – The scope of services and supports beneficiaries receive varies as follows:

   a. Community Medicaid. Beneficiaries eligible for health coverage receive the full scope of primary care essential benefits – including acute, subacute and rehabilitative services – as well as thirty (30) days of LTSS and, based on need, a limited set of LTSS preventive services. Subchapter 10 Part 1 of this Chapter identifies the scope of covered services available through the managed care and fee-for-service delivery options for IHCC group beneficiaries eligible for full Medicaid benefits. Note:

      (1) The Medicaid benefits MPPP participants are eligible to receive may be limited to premium payment assistance only, depending on the basis of eligibility. See § 05-1.6.1 of this Chapter.

      (2) For the scope of services covered under the Sherlock Plan, see Subchapter 15 Part 1 of this Chapter.

   b. Medicaid LTSS. Medicaid LTSS includes health supports, personal care, and social services in an institutional or home and community-based setting. The scope of Medicaid LTSS a beneficiary receives is based on need -- health status and functional ability -- and personal health preferences and goals. Persons eligible for Medicaid LTSS also receive the full scope of primary care essential benefits authorized under the Medicaid State Plan. To be eligible for Medicaid LTSS, a person must meet a specific set of financial and clinical criteria that do not apply to applicants seeking coverage through other Medicaid eligibility pathways.

3. Integrated Care -- The State's Integrated Care Initiative (ICI) provides IHCC group members who have Medicare and other forms of third-party coverage who qualify for LTSS in accordance with the provisions set forth in the Medicaid Code of Administrative Rules, Overview of Medicaid and SSI-Related Coverage Groups, to obtain the coordinated services they need across the care continuum through a single plan. Subchapter 10

Part 1 of this Chapter covers these options and the process for plan selection and enrollment.

4. Retroactive Eligibility – Up to three (3) months of Medicaid retroactive coverage is available for certain IHCC group beneficiaries. To qualify, the State must determine that a person would have met the applicable eligibility criteria for his or her coverage group if the application was submitted during the retroactive period. The State provides reimbursement to providers only for Medicaid covered services, however. The provisions in Subchapter 5 Part 3 of this Chapter explain the process for obtaining retroactive coverage in greater detail.

1.9 Service Delivery Options

A. The service delivery options for IHCC group members are dictated in large part by type of Medicaid health coverage and eligibility pathway. Subchapter 10 Part 1 of this Chapter.

B.

Overview IHCC Group Service Delivery	
Eligibility Pathway	**Service Delivery Option**
SSI, EAD with no Medicare	Rhody Health Partners
SSI, EAD with Medicare	Rhody Health Options, PACE, Fee-for-Service (FFS) w/Community Health Team, or FFS-only
LTSS No Medicare	Same as above
LTSS with Medicare	Rhody Health Options, Medicare-Medicaid Plan II, PACE
Sherlock Plan – EAD and LTSS	FFS

Overview IHCC Group Service Delivery	
Eligibility Pathway	**Service Delivery Option**
Medically Needy – non-LTSS	FFS

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TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 40 - MEDICAID FOR ELDERS AND ADULTS WITH DISABILITIES

SUBCHAPTER 00 - INTEGRATED COVERAGE GROUPS

PART 1 - Overview of Medicaid Integrated Care Coverage (210-RICR-40-00-1)

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