STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
PUBLIC NOTICE OF PROPOSED RULE-MAKING

PUBLIC HEARING SCHEDULED

In accordance Rhode Island General Laws (RIGL) 42-35, notice is hereby given that the Department of Human Services proposes to amend the following DHS rule:

MEDICAL ASSISTANCE PROGRAM
Section 0348: RIte Care Program

Effective October 1, 2011, the proposed amendments seek to increase the premium share requirements for RIte Care recipients as follows: Households with a monthly family income over 150% of the federal poverty level (FPL) and not greater than 185% of the FPL will have a premium increase from $61.00 to $91.00. Households with a monthly family income over 185% of the FPL and not greater than 200% of the FPL, will have a premium increase from $77.00 to $113.00. Households with a monthly family income over 200% of the FPL and not greater than 250% of the FPL will have a premium increase from $92.00 to $122.00. The proposed increases to premium share requirements are consistent with the final budget that passed the General Assembly this legislative session.

In the development of these rules, consideration was given to the following: (1) alternative approaches; and (2) overlap or duplication with other statutory and regulatory provisions. No alternative approach or duplication or overlap was identified based upon available information.

These proposed rules are accessible on the R.I. Secretary of State website (http://www.sec.state.ri.us/ProposedRules/) and the DHS website (www.dhs.ri.gov) or available in hard copy upon request (401 462-2018 or RI Relay, dial 711). A public hearing will be held to consider the proposed rule adoption and proposed amendment on **Thursday, August 25, 2011 at 4:00 PM at the DaVinci Center for Community Progress, Inc., 470 Charles Street, Providence, RI 02904.** Persons wishing to testify may do so by signing up at the Hearing or by submitting written testimony by Wednesday, September 7, 2011 to Kimberly Merolla-Brito, Office of Policy Development, RI Department of Human Services, Louis Pasteur Building, 57 Howard Avenue Fl # 1, Cranston, RI 02920.

The Hearing will begin at 4:00 P.M. and will conclude when the last speaker finishes testimony or at 6:00 P.M., whichever occurs first. The seating capacity of the DaVinci Center will be enforced and therefore the number of persons participating in the Hearing may be limited at any given time by the hearing officer, in order to comply with safety and fire codes.

The DaVinci Center is accessible to the handicapped. Individuals with hearing impairments may request an interpreter's presence by calling 711 or Relay RI 1-800-745-6575 (Voice) and 1-800-745-555 (TDD). Requests for this service must be made at least 72 hours in advance of the Hearing date.

The Department of Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief or handicap.

0348 RITE CARE PROGRAM

0348.05 OVERVIEW OF THE PROGRAM

REV:09/2010

A. Purpose and Method

RIte Care is a statewide managed care demonstration project that was established in 1994 under a Title XIX waiver. The project's goal is to increase access to primary and preventative care for the following recipients:

1. the state TANF Program;
2. low-income families;
3. Medical Assistance Only Families (MAOF);
4. pregnant women and children who are uninsured or who do not have access to affordable health coverage; and
6. under-insured pregnant women and children.

Beneficiaries receiving Medical Assistance through the RIte Care program are enrolled in a health maintenance organization (HMO) which uses a primary care provider to coordinate all medically necessary health care services through an organized delivery system. The Department of Human Services (DHS) contracts with HMOs to provide these health services to members at a capitated rate or fixed cost per enrollee per month.

Under the RIte Care program, expansions in the eligibility criteria for MA are implemented concurrently with a managed care program model of health care delivery. The expanded eligibility is directed at resolving the problems caused by a lack of access to coverage.

The managed care delivery system is designed to ensure access to an efficient, organized and available health care delivery system.

Section 1931 families (including RIW families), Waiver Families, children under the age of nineteen (19), Katie Beckett children, Adoption Subsidy children, SSI recipients under age twenty one (21), other Medical Assistance Only Families (with the exception of Medically Needy flex-test recipients), and child care providers eligible under the Child Care Provider RIte Care Program may receive their medical care through the RIte Care managed care delivery system. Families with access to DHS approved Employer-sponsored health insurance plans are evaluated for participation in the Rite Share Premium Assistance Program in accordance with provisions contained in Section 0349.

Adults in these families are required to enroll any MA eligible family members in the DHS-approved employer plan as a condition of retaining MA eligibility.

Although Medically Needy flex-test cases may receive services from RIte Care providers, they are paid and delivered on a fee-for- service basis rather than through an HMO.

The eligibility rules in this section apply specifically to all pregnant women with countable family incomes not exceeding three hundred fifty percent (350%) of the Federal Poverty Level (FPL), to children under nineteen (19) years of age with countable family incomes

not exceeding two hundred fifty percent (250%) of FPL, and to families with children under the age of eighteen (18) with income not exceeding one hundred seventy-five percent (175%) of FPL.

The eligibility of other Medical Assistance populations is determined by the rules appropriate to their specific program.

These rules are found in the Rhode Island Department of Human Services Manual, the Medical Assistance Program regulations located in Section 0300 et seq.

0348.05.05 Legal Authority and Program Management

REV:09/2010

Title XIX of the Social Security Act provides the legal authority for the Medical Assistance Program. The RIte Care program operates under a waiver granted by the Secretary of Health and Human Services (HHS) pursuant to Section 1115 of the Social Security Act.

The RIte Care Program is administered by the Department of Human Services' Center for Child and Family Health (CCFH).

The RIte Care Managed Care Consumer Advisory Committee was established by Executive Order in February, 1994. The Committee is available to RIte Care consumers to address suggestions, complaints or related issues.

0348.10 RITE CARE COVERAGE GROUPS

REV:10/2005

The RIte Care population consists of eligible groups representing a consolidation of various Title XIX aid categories and State Funded aid categories. Qualification for the program is based on a combination of factors including: family composition, income, health insurance status, age, child care provider status, and/or pregnancy status, depending on the aid category.

0348.10.05 Title XIX Groups

REV:09/2010

RIte Care provides coverage through Health Maintenance Organizations (HMOs) for the following populations eligible under the Title XIX program:

- SECTION 1931 FAMILIES (Including Rhode Island Works (RIW) Program Cash Recipients) AND OTHER MEDICAL ASSISTANCE FAMILIES WITH THE EXCEPTION OF MEDICALLY NEEDY FLEX-TEST CASES

  See RI Department of Human Services Rules, Section 1400, et seq. (Rhode Island Works (RIW) Program cash recipients). See Section 0348.05.10 for a listing of who is included in Medical Assistance Only Families and Section 0300 et seq. (Medical Assistance Only Family recipients) for definitions and eligibility criteria.

- FAMILIES WITH CHILDREN UNDER THE AGE OF EIGHTEEN (18) - FAMILY WAIVER GROUP

  This group consists of families with income greater than one hundred ten percent (110%) of FPL and less than or equal to one hundred seventy-five percent (175%) of FPL who meet all other requirements for Section 1931 eligibility. These families receive the full scope of categorically needy services.

- CHILDREN UNDER AGE NINETEEN (19)

  Children, including children in foster care, under nineteen (19) years of age residing in households with countable income not exceeding two hundred fifty percent (250%) of the FPL.

- NON IV-E FOSTER CHILDREN UNDER AGE TWENTY-ONE (21)

  Children in foster family care (as defined in Section 0342.75 and 0342.80) who are under the age of twenty-one (21) with countable income not exceeding two hundred fifty percent (250%) of the FPL.

- IV-E FOSTER CHILDREN AND CHILDREN RECEIVING ADOPTION SUBSIDY (Section 0342.70)

  Eligible members of these coverage groups who are covered by employer-sponsored or other third party health insurance, may receive Medical Assistance on a fee-for-service basis, rather than through enrollment in a RIte Care Health Plan.

- NON IV-E ADOPTION SUBSIDY CHILDREN WHO ARE UNDER AGE TWENTY-ONE (21) (Section 0342.85)

  Eligible members of these coverage groups who are covered by employer-sponsored or other third party health insurance, may receive Medical Assistance on a fee-for-service basis, rather than through enrollment in a RIte Care Health Plan.

- SSI RECIPIENTS UNDER AGE TWENTY-ONE (21) (Section 0370.05)

  Eligible members of these coverage groups who are covered by employer-sponsored or other third party health insurance, may receive Medical Assistance on a fee-for-service basis, rather than through enrollment in a RIte Care Health Plan.

- DISABLED CHILDREN - KATIE BECKETT COVERAGE (Section 0370.20 and 0394.35)

  Children under age nineteen (19) who: are living at home; require a hospital, nursing home or ICF-MR level of care; and would qualify for Medical Assistance if in a medical institution.

  Eligible members of these coverage groups who are covered by employer-sponsored or other third party health insurance, may

receive Medical Assistance on a fee-for-service basis, rather than through enrollment in a RIte Care Health Plan.

- o SSI RECIPIENTS OVER AGE TWENTY-ONE (21)

  Individuals in the SSI eligible group under age twenty-one (21) who are enrolled in RIte Care managed care may continue enrollment in a RIte Care health plan when they turn twenty-one (21) years of age until such time as SSI eligibility is discontinued.

  Eligible members of this coverage group, who are covered by employer-sponsored or other third party health insurance, may receive Medical Assistance on a fee-for-service basis, rather than through enrollment in a RIte Care Health Plan.

- o PREGNANT WOMEN

  Pregnant women with countable income not exceeding two hundred fifty percent (250%) of the FPL.

- o EXTENDED FAMILY PLANNING GROUP

  Individuals in this RIte Care waiver group are entitled to a limited scope of services rather than comprehensive benefits. This waiver group consists of women who meet the following conditions:

  - o Have countable income above the Medically Needy income limit;
  - o Have qualified through Medical Assistance Only Family (MAOF) status, or are Pregnant Women with countable income not exceeding two hundred fifty percent (250%) of FPL status;
  - o Were pregnant and are now sixty (60) days postpartum or sixty (60) days post-loss of pregnancy; and,
  - o Are subject to losing eligibility for Medical Assistance.

Medically Needy flex-test cases are included in the RIte Care Program but receive services in the fee-for-service system. The income deeming methodology permitted by the waiver is applied to new Medically Needy flex-test applicants.

With the exception of Katie Beckett children, long term care coverage groups (Section 0394) are not included in the RIte Care Program.

0348.10.10 State Funded RIte Care Coverage Group

REV:06/2008

State Funded RIte Care coverage groups include:

1. State funded pregnant women (non-Title XIX MA eligible);

2. Non-MA eligible post-partum or post-loss of pregnancy

women who are eligible for a special family planning benefit.

0348.10.10.05 State Funded Pregnant Women

REV:09/2010

A. This group is composed of the following two categories of women who either are pregnant or are within sixty (60) days postpartum or post-loss of pregnancy:

While not actual Title XIX recipients with federal funding, individuals in both categories of this State-funded, non-MA group receive the same HMO in-plan benefits as Title XIX pregnant women.

1. Above Two Hundred Fifty (250%) percent Category:
   Women whose countable family income is above two hundred fifty percent (250%) of the FPL, but does not exceed three hundred fifty percent (350%) of the FPL.
   a. Women in the "At or Above 250% Category" are not entitled to any fee-for-service coverage for medical services, including those rendered prior to enrollment in a health plan.

2. At or Below Two Hundred Fifty Percent (250%) Category:
   Those women whose countable family income does not exceed two hundred fifty percent (250%) of the FPL, and are ineligible for Title XIX due to other circumstances, such as citizenship status.
   a. Women in the "Below 250% Category" are also eligible for fee-for-services benefits beginning on the first day of the month of application. Retroactive coverage for the three (3) months prior to application is not available for women in this group.

3. In addition to these benefits, undocumented non-citizen pregnant women may be eligible for emergency services under the regular Title XIX rules of the Medical Assistance Program.

0348.10.15 Non-Title XIX Related Groups

REV:09/2010

In addition to the RIte Care Title XIX and State Funded coverage groups, health plans participating in RIte Care must make coverage available without evidence of insurability to three other classes of individuals. These are individuals who are allowed to participate in the Managed Care delivery system by paying their own premiums. These individuals are ineligible for Title XIX or State Funded coverage and, although they are participating in managed care, they are considered outside of the actual RIte Care Program.

The Non-Title XIX Related Group contains individuals who are:

- THE CONVERSION GROUP
  These are RIte Care health plan members who have lost their eligibility for the program. It also includes individuals who are eligible for the Extended Family Planning benefit but who

choose to waive this benefit in favor of a conversion option.

- o UNINSURED CHILDREN UP TO AGE 8 WITH COUNTABLE FAMILY INCOME ABOVE 250% OF THE FPL
  These are children up to age 8 living in families who are uninsured or under-insured and whose countable income is above 250% of the FPL.

- o PREGNANT WOMEN WITH INCOME GREATER THAN 350% OF THE FPL
  This non-MA group includes pregnant women who are uninsured or under-insured for maternity care and whose countable family income is above 350% of the FPL.

0348.15 APPLICATION PROCESS

REV:11/1998

Any person may request information about the agency's assistance programs either by telephone, mail, or in person. A request for information may be followed by an application for Medical Assistance (RIte Care) or another form of assistance. Authorized agency staff must furnish information to the inquiring person in accordance with Department of Human Services policy and procedure. The RIte Care Info Line staff also furnishes information upon request regarding the RIte Care Program and how to apply.

DHS provides two processes for families applying for Medical Assistance, as follows:

- o Combined Application (Forms DHS-1, DHS-2 and RC-100)

  Families and pregnant women applying for other DHS programs as well as Medical Assistance or RIte Care must complete the DHS-1 and DHS-2 forms, and a face-to-face interview is required. An applicant may be assisted in this application process, including completion of the DHS-1 and DHS-2, by one or more individuals of choice, and when accompanied by such individual(s), may be represented by them.

- o Short Form Application (Form MARC-1)

  Families, children and pregnant women applying only for Medical Assistance (RIte Care) may complete the MARC-1 application form and mail it to the agency. A face-to-face interview is not required when the MARC-1 form is used.

  Rhode Island Works (RIW) Program cash recipients access managed care by virtue of their cash eligibility as determined through the RIW application process. No separate screening or application process is required.

  Applicants for the RIte Care Program may submit applications at any DHS district office or any site designated by DHS.

  Information regarding the RIte Care Program and how to apply for these benefits can be obtained by calling the DHS Information Line, the RIte Care Info Line, or a DHS district office.

0348.15.05 RIte Care Info Line

REV:01/2002

The RIte Care Information Line (Info Line), telephone 462-1300 (English), 462-1500 (Spanish), 462-3363 (TDD/TTY for hearing impaired) is a statewide service operated by the Department of Human Services which provides access to program information to all potential RIte Care eligibles.

0348.15.10 RIte Care Screening

REV:09/1998

When a request for information about Medical Assistance or the RIte Care Program is received in the DHS district office and the inquiring person expresses a desire to apply, the agency representative attempts to determine whether a combined application is needed or whether a short form application meets the need of the prospective applicant. If the prospective applicant requests or requires a combined application, a screening interview is arranged in accordance with procedures outlined in Section 0502.

COMBINED APPLICATION: The Screening Interview

During the screening interview the Rhode Island Works (RIW) Program social caseworker, in addition to offering other available services, explains and offers Early Periodic Screening, Diagnosis and Treatment (EPSDT) services to the applicant family for potentially eligible members under age 21 years.

The RIW Program social caseworker offers assistance to the applicant, if needed, to complete the DHS-1 and DHS-2 and indicates what documentation must be furnished. At the same time, the applicant is advised that if eligibility is found to exist, eligibility begins on the first day of the month on which the signed DHS-1 is date-stamped in the DHS district office or designated outstation site.

However, State funded pregnant women whose countable family income is greater than 250% of the FPL cannot access medical services prior to enrollment in a health plan (normally within ten days after eligibility is determined.)

If the person chooses to become an applicant, the DHS-1 should be completed, signed and date-stamped before the individual leaves the office in order to establish the application date. If the applicant wants to withdraw the request for assistance, the withdrawal of application statement on the DHS-1 is signed and dated by the applicant.

The social caseworker reviews the family income and composition relative to the pregnancy status of female applicants in an effort to identify RIte Care characteristics. An appointment is then made for an intake interview with the appropriate agency representative.

SHORT FORM: The Application Process

Upon request, the DHS Information Line staff, the RIte Care Info Line staff and the DHS district office staff shall send prospective

applicants the short form application (MARC-1). In addition, MARC-1 forms are made available to prospective applicants at other appropriate locations, including community health centers and disproportionate share hospitals, as the agency shall determine. The applicant may be assisted in completing the form by persons of his/her choice.

When the completed short form application is received by the agency, it is date-stamped and forwarded to the appropriate District office for eligibility determination by the appropriate agency representative. If eligibility is found to exist, eligibility begins on the first day of the month in which the signed MARC-1 is date- stamped in the DHS district office or designated outstation site in a community health center or disproportionate share hospital.

However, State-funded pregnant women whose countable family income is greater than 250% of the FPL cannot access medical services prior to enrollment in a health plan (normally within ten days after eligibility is determined).

If necessary documentation is missing from the short form application, the agency representative attempts to obtain copies from the applicant. In exceptional situations, such as those requiring complicated documentation of self-employment earnings, for example, the applicant may be required to appear for an interview, at the discretion of the agency representative.

0348.15.15 Worker Responsibilities

REV:01/2002

Initial case responsibility is delineated as follows.

Rhode Island Works (RIW) Program social caseworkers have responsibility for determining initial eligibility for all pregnant women with one exception. The exception is a pregnant woman and her family members who are RIW cash applicants.

Households which contain RIW cash applicants and RIte Care/MA applicants are the responsibility of the RIW eligibility technician.

A household which contains a pregnant applicant and which also contains a combination of Medical Assistance Only Family applicants and potential RIte Care eligible children is the responsibility of the RIW social caseworker.

A household which does not contain a pregnant applicant but which does contain a combination of Medical Assistance Only Family applicants and potential RIte Care eligible children is the responsibility of the MA eligibility technician for initial processing of eligibility determinations when seen in the district office. These households are the responsibility of the RIW social caseworker when seen at an outstation site.

A household containing a combination of RIW cash applicants, RIte Care eligible children, and MAOF applicants is the responsibility of the RIW Program eligibility technician.

Ongoing case responsibility is delineated as follows.

RIte Care workers have ongoing case responsibility for "RIte Care Only" recipient households.

MA eligibility technicians have ongoing case responsibility for "compound households" which are comprised of pregnant women and/or RIte Care eligible children as well as family members who do not fit this criteria but who are eligible as Medical Assistance Only Families.

After the initial eligibility determination and case processing, the RIW social caseworker transfers an MA compound household case containing a pregnant woman to the MA Eligibility Unit for on-going case responsibility for the entire compound case.

MA eligibility technicians have ongoing responsibility for cases which contain a combination of Medical Assistance Only Family recipients and RIte Care recipients.

0348.15.15.05 Case Transfers

REV:05/1997

Transfers in worker responsibility occur when the family composition changes. If the change is from a RIte Care Only household to a compound household, the Rhode Island Works (RIW) Program supervisor transfers the case to the appropriate Eligibility Unit. If the change is from a compound household to a RIte Care Only household, the eligibility supervisor transfers the case to a RIW service unit.

For example, when an older child who will be MA eligible returns to live with the household, case responsibility is transferred from a RIW social caseworker to an MA Eligibility Unit. Cases are transferred following standard Departmental and InRhodes transfer procedures.

Medical coverage and delivery of services are not adversely affected by transfers in case responsibility.

0348.15.20 Decision on Application

REV:07/2002

Applications are acted upon promptly. A decision on eligibility or ineligibility for Medical Assistance must be made within thirty (30) days of the application filing date. This standard is not used as a waiting period before granting assistance nor as a basis for denial of an application. The applicant must be informed of the reason for any delay in a decision and his/her right to a hearing, if the delay is beyond thirty (30) days.

When the applicant is found to be ineligible or the applicant makes the decision after signing the application that he/she does not want assistance, the eligibility technician or social caseworker notifies the applicant of the rejection through an InRhodes generated notice. This notice informs the applicant at the same time of his/her right to appeal the decision, and the method by which the applicant can request a hearing.

When the applicant is found to be eligible, the acceptance date for medical coverage is the first day of the month of application. Pending enrollment into either a RIte Care health plan or RIte Share approved ESI plan, Medical Assistance coverage is on a fee-for-service basis.

However, State funded pregnant women whose countable family income is greater than two hundred fifty percent (250%) of the Federal Poverty Level(FPL) cannot access medical services prior to enrollment in a health plan (normally within ten (10) days after eligibility is determined).

Requests for retroactive eligibility are evaluated at the time of application, but must not delay a decision on prospective eligibility. Retroactive eligibility is not available to family-related RIte Care coverage groups, with the exception of foster children and adoption subsidy coverage groups.

Retroactive coverage is available to other MA coverage groups, including SSI-related eligible individuals and SSI-related Medically Needy flex test cases. If eligibility exists, retroactive payment for services is on a fee-for-service basis.

0348.20 NON-FINANCIAL REQUIREMENTS

REV:06/2008

To be eligible for the RIte Care program a family must meet the program's non-financial, financial and cooperation requirements.

BASIC NON-FINANCIAL REQUIREMENTS

All participants in the RIte Care program must meet basic Medical Assistance eligibility criteria.

Applicants for RIte Care, Section 1931 or MA Family Waiver coverage using either the combined application form or the mail-in application form must meet the following requirements:

- Provide proof of citizenship for U.S. citizen members of the Applicant Unit.

- Provide proof of identity for U.S. citizen members of the Applicant Unit.

- Provide a valid Social Security number (SSN) for all members of the Applicant Unit. This requirement is waived for undocumented aliens who cannot obtain a Social Security number. Social Security numbers need not be verified by documents submitted by the applicant, but are subject to verification by DHS staff. Non-applicant members of the Financial Unit are encouraged to provide a SSN voluntarily, if they have one, to facilitate verification of income and determinations of continuing eligibility. However, unwillingness on the part of a non-applicant to provide a SSN upon request cannot be used as a basis for denying eligibility to a member of the Applicant Unit who has met this requirement and provided a SSN;

- Provide proof of immigration status or information regarding

other alien status for non-citizen members of the Applicant Unit only. Pregnant women who are unable to document their immigration status may be eligible for RIte Care under State-Funded coverage groups. (See Sections 0348.10.10.05). Non applicant members of the Financial Unit, who work for employers offering health insurance, are asked for general information about citizenship status (e.g., citizen versus qualified immigrant). This information is used to determine whether employer contact is necessary for the purposes of RIte Share. No employer contact is made for non-applicants who are not US citizens, or who do not have qualified immigration status, as they are generally prohibited from receiving MA through RIte Share or RIte Care under State and federal law.

- Meet the MA relationship requirement for Section 1931 or Family Waiver coverage. Self report of relationship on the signed MA application form is sufficient verification of this requirement, unless the information provided is inconsistent with related documentation known to or on record with DHS. Relationship is not required for Poverty Level/RIte Care children. (See DHS Manual Sections 0328.10 for relationship requirement and 0328.10.05 for verification of relationship);

- Reside in the State of Rhode Island. A Rhode Island address on the MA application form is sufficient for this requirement, unless it is inconsistent with other documented information known to DHS. Non-citizens who hold Temporary Visitors Visas must establish and provide appropriate evidence verifying an intent to stay and live in Rhode Island in order to meet this requirement for MA eligibility;

- Not reside in a public institution, including correctional facilities and public psychiatric hospitals.

ADDITIONAL NON-FINANCIAL REQUIREMENTS

- Provide proof of pregnancy, if appropriate;

- Provide information on health insurance status.

COOPERATION REQUIREMENTS

- Third Party Liability (TPL)

  Third Party Liability (TPL) refers to any individual, entity (e.g., insurance company) or program (e.g., Medicare) that may be liable for all or part of a RIte Care member's health coverage. Under Section 1902(a)(25) of the Social Security Act, the DHS is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medical Assistance recipient.

The RIte Care applicant is required to furnish information on the application form about all sources of TPL.

The health plan and the State are responsible for identifying and pursuing TPL for individuals covered by employer-sponsored health insurance plans through the RIte Share program.

DHS reserves the discretion to provide Medical Assistance wrap around coverage, as an alternative to coverage in a RIte Care plan, to an eligible individual who has comprehensive health insurance through a liable third party, including (but not limited to) absent parent coverage. Such wrap around coverage must be equivalent in scope, amount and duration to that provided to MA eligible individuals enrolled in ESI through the RIte Share program (Section 0349) and include payment for: any cost-sharing obligations in excess of the amounts established in Section 0348.40; and MA required health care services not covered by the other source of health insurance.

- Referral to Child Support Enforcement

  With the exception of pregnant women, the eligibility technician or Rhode Island Works Program social caseworker must refer all families with an absent parent to the division of Child Support Enforcement within the Department of Human Services. As a condition of eligibility, the applicant/recipient is required to cooperate in establishing the paternity of a child born out of wedlock for whom the applicant/recipient can legally assign rights and in obtaining medical care support and medical care payments for himself/herself, as well as for any other person for whom the applicant/recipient can legally assign rights.

  The applicant/recipient is also required to cooperate in identifying and providing information to assist Child Support Enforcement in pursuing any third party which may be liable to pay for care and services provided by MA. Notwithstanding this requirement, Medical Assistance may not be withheld from any child because of an adult's failure to cooperate with Child Support Enforcement.

  Every applicant or recipient has the right to claim good cause for refusal to cooperate in child support enforcement. To claim good cause there must be a verifiable on-going reason for the individual to not cooperate.

  The applicant or recipient is given an opportunity to claim good cause for refusing to cooperate. An AP-35 is read by the applicant, explained by the eligibility technician or Rhode Island Works Program social caseworker and signed and dated, in duplicate, by each. The applicant/recipient retains a copy. The second copy is filed in the case record.

  If good cause is claimed, the applicant/recipient is advised that she/he must state the basis of the claim and must present corroborative evidence within twenty (20) days of the claim; or, she/he must provide sufficient information to enable the investigation of the existence of the circumstance; or, provide sworn statements from individuals to support the claim as specified on the AP-35.

  A determination of good cause is based on the evidence

supplied which establishes the claim; or, an investigation by the agency of the circumstance which confirms the claim; or, a combination of evidence and investigation; or, when the claim is one of anticipated physical harm without evidence, the investigation supports the creditability of the claimant. The determination as to whether good cause does or does not exist should be made within thirty (30) days of the good cause claim unless the record documents that the agency needs additional time because the information required to verify the claim cannot be obtained within the time standard.

If the reason the information is not available is that the client did not present the corroborative Evidence within twenty (20) days of the claim, the record must document that the agency determined that the applicant/recipient required additional time to obtain the evidence, the amount of additional time allowed and that this decision had supervisory approval.

The final determination that good cause does or does not exist, including the findings and basis for the decision, must be included in the case log. The final determination is the responsibility of the eligibility technician or the Rhode Island Works Program social caseworker.

A review of the good cause decision must be made at each Determination of Continuing Eligibility (DOCE). If it is determined that circumstances have changed Such that good cause no longer exists, there must be enforcement of the cooperation requirements.

o Cost Sharing Requirements

Certain families and children one (1) year of age and over are subject to cost sharing requirements. These individuals must cooperate in making required premium payments in order to remain eligible for Medical Assistance. Failure to make a required premium payment, without good cause, will result in disenrollment from the health plan and loss of MA eligibility for a period of three (3) months. (Section 0348.40)

NOTE: Pregnant women whose countable family income is above two hundred fifty percent (250%) but not exceeding three hundred fifty percent (350%) of FPL must pay the full State negotiated capitation rate to the health plan in addition to the schedule of point-of-service co-payments.

0348.25 FINANCIAL REQUIREMENTS

REV:09/2010

Income requirements include:

1. Proof of household's earned income;
2. Proof of household's unearned income including proof of child support and/or alimony payments.

The RIte Care family income methodology incorporates income exclusions and income disregards.

A. EXCLUDED INCOME

Certain types of income are excluded, i.e. not considered, under the rules of the RIte Care Program. For a list of the types of income excluded from financial determinations, see Section 0330.20 of the Rhode Island Department of Human Services Rules.

B. EARNED INCOME DISREGARDS

Portions of earned income may be disregarded before arriving at the amount of income which will be countable income. In addition to excluded income, a portion of earned income may be disregarded (deducted), as well as a portion of dependent care expenses. For RIW- eligibles, RIW disregards apply. For non-RIW eligibles, the RIte Care Program recognizes a $90 work expense disregard, the dependent care disregard, and the $50 child support disregard.

1. $90 Work Expense Disregard
   The work expense disregard allows the disregard of the first $90 of an individual's monthly earned income.
2. Dependent Care Disregard
   The dependent care disregard (DHS Day Care Subsidy plus the individual's copayment) allows a disregard not to exceed $175 per month per child age two (2) years and older or an incapacitated adult. For a child under the age of two (2) years, this disregard may not exceed $200 per month. Consideration of the dependent care expense is only given when the care is provided by a person not living in the child's or incapacitated adult's household.
3. $50 Child Support Disregard
   A $50 child support disregard is applied to the gross amount of the family's total child support income from all sources.

C. COUNTABLE INCOME

1. In family income eligibility determinations, the amount of the family's countable income must first be determined and then compared to the program's income standard. If countable income is equal to or less than the standard, eligibility exists. There is no Flex-test of income in the determination of eligibility for RIte Care individuals.

2. Eligibility for RIte Care cannot be established if the countable income is greater than the standard.

3. When determining countable income:
   a. eliminate excludable income
   b. apply the $90 earned income disregard to the earned income of each employed individual
   c. if applicable , apply the dependent care disregard to the family's income
   d. apply the $50 child support disregard to the family's income.

   The balance of the earned income together with any unearned income is the countable income.

0348.30 INCOME METHODOLOGY

REV:09/1998

There are three components of RIte Care family income methodology: Household Unit, Applicant Unit, and Financial Unit.

The following definitions are employed to identify the three components.

1. HOUSEHOLD UNIT
   The Household Unit is comprised of ALL individuals listed on the application form as living in the household. The Household Unit is used to:
   a. identify RIte Care applicants,
   b. evaluate members according to the MA Program's rules of relationship, as set forth in Section 0328.10,
   c. assess financial responsibility.
      Each individual must be evaluated to determine if the individual is:
      i. A RIte Care or other Medical Assistance applicant;
      ii. A relative of acceptable degree according to the MA Program's rules of relationship;
      iii. Financially responsible for another individual in the Household Unit who is an applicant.

2. APPLICANT UNIT
   The Applicant Unit is used to identify those members of the Household Unit who are APPLYING for coverage. The members of the Applicant Unit will form the foundation on which the third component, the Financial Unit, will be constructed.
3. FINANCIAL UNIT
   The Financial Unit has two elements:
   - the total number of individuals in the financial unit and
   - the total amount of countable income those individuals bring to the financial unit.

   The Financial Unit is used to determine the amount of the family's countable income and the size of the Medical Assistance income standard against which that income will be tested.

   The Financial Unit draws its members only from the Household Unit. No consideration is given for support paid by household members for individuals who do not live in the applicant household. A referral to the Rhode Island Child Support Services (RICSS) initiates the process of obtaining support from absent parents.

   a. CONSTRUCTING THE FINANCIAL UNIT
      When constructing the Financial Unit, include the following household members and their countable income:
      FIRST include:
      i. all applicants; and,
      ii. all household members for whom an applicant has financial responsibility.

      NEXT, include:
      iii. all household members who have financial responsibility for an applicant; and,
      iv. any other household member for whom such individual, in 3., above, has financial responsibility.

      FINALLY, include (if not already included):
      v. the step-parent of an applicant minor child; and,
      vi. any other household members for whom the step-parent

has financial responsibility.

b. DETERMINING THE FINANCIAL UNIT
When determining the Financial Unit, include the following individuals and their countable income:
i. IF THE APPLICANT IS A CHILD, include:
a) the applicant child.
b) the child's natural or adoptive parent(s) and minor siblings, and
c) the child's step-parent and minor step-siblings (if any), if living in the household whether or not they are applying.

ii. IF THE APPLICANT IS A PARENT, include:
a) the applicant parent.
b) the parent's minor natural or adoptive children,
c) the parent's spouse, and
d) the parent's minor step-child(ren) (if any), if living in the household and whether or not they are applying.

iii. IF THE APPLICANT IS A STEP-PARENT, include:
a) the applicant step-parent.
b) the step-parent's minor natural or adoptive children,
c) the step-parent's spouse, and
d) the step-parent's minor step-child(ren) (if any), if living in the household and whether or not they are applying.

c. GROUP SIZE AND COUNTABLE INCOME
Once the financial unit has been constructed, determine:
i. the total number of individuals in the financial unit; and,
ii. the total amount of countable income in the financial unit.

For a pregnant woman, the number of individuals in the financial unit includes the unborn. If the pregnancy involves multiple unborns, the size of the financial unit increases appropriately to include all the unborns.

d. STANDARD OF ELIGIBILITY
When the total number of individuals and the total amount of countable income of the Financial Unit has been determined, establish eligibility as follows:
FOR EACH APPLICANT:
i. determine the individual's appropriate Medical Assistance income standard, e.g., one of the Federal Poverty Level standards if the applicant is a poverty level pregnant woman or a poverty level child, or the Categorically Needy standard, or the Medically Needy standard;
ii. determine the amount of the standard to be tested based on a group size comparable to the total number of individuals in the Financial Unit;
iii. compare the total amount of countable income of the Financial Unit to the standard for the group size comparable to the total number of individuals in the

Financial Unit; and,

iv. certify each eligible applicant for the correct scope of benefits.

0348.35 ELIGIBILITY DETERMINATION

REV:09/2010

DHS RESPONSIBILITY - RITE CARE ELIGIBLE GROUPS

The Department of Human Services (DHS) has sole authority for determining whether individuals or families in the RIte Care Eligible Groups meet all eligibility criteria and are therefore eligible to enroll in a RIte Care health plan.

DHS STAFFING

RIte Care eligibility determinations are made either by an MA or RIW Program eligibility technician or a Rhode Island Works Program social caseworker.

Medical Assistance (MA) eligibility technicians complete RIte Care eligibility determinations for MA "compound households," with the exception of the compound households including pregnant women.

Initial eligibility for these cases is determined by the Rhode Island Works Program social caseworker. The case is then transferred to the MA eligibility technician for assumption of on-going responsibility for the entire case.

For combination Rhode Island Works Program and RIte Care/MA households, Rhode Island Works Program eligibility technicians assume responsibility for the case.

Rhode Island Works Program social caseworkers complete eligibility determinations for all households containing a pregnant woman applying for Medical Assistance Only, when the combined application form (DHS-1 and DHS-2) is used. Compound household cases are then transferred to the MA eligibility technician following standard transfer policy and procedure. The RIte Care Only cases remain in the Rhode Island Works Program social caseworker's caseload on an on-going basis.

When the short form (MARC-1) application is used, Medical Assistance (MA) eligibility technicians complete the eligibility determinations, forwarding the RIte Care Only cases to a Rhode Island Works Program social caseworker as the district office supervisor shall direct.

DHS OUTSTATION SITES

DHS eligibility staff are stationed full time at DHS district offices throughout the State. DHS may also provide application assistance at community health centers, hospital clinics, and other locations as necessary through contracted arrangements.

HEALTH PLAN RESPONSIBILITY - NON-TITLE XIX RELATED GROUP

Health plans have authority for determining whether individuals or families meet the eligibility criteria for the Non-Title XIX Related

Group. Health plans do not determine eligibility for Title XIX RIte Care Coverage Groups or for State Funded Pregnant Women.

0348.35.05 Expedited Eligibility

REV:09/1998

Whether or not the short form (MARC-1) application is used, an expedited eligibility process is available for pregnant women.

Women whose pregnancy has been verified may be eligible for Medical Assistance through the RIte Care Program. Pregnant applicants who are applying for financial assistance as well as medical coverage are seen according to the appointment scheduling described in DHS Manual, Rhode Island Works Program, Section 0802.05.05.

0348.35.05.05 Streamlined Application Process

REV:09/1998

Under the expedited application process, the eligibility determination is streamlined. Eligibility is expedited for pregnant women. The intake appointment (necessary when the combined application is used and optional to applicants who use the short form) is scheduled within 10 days of the request for RIte Care. The decision on the application is rendered within 30 days of the application filing date.

Expedited eligibility for pregnant women may be granted based on medical verification of pregnancy. Medical verification of pregnancy results from either a physical examination by a doctor or a test from a medical laboratory.

A free pregnancy test is available at a number of participating sites. The Rhode Island Works Program social caseworker gives the applicant a referral form and a list of sites where the applicant may receive these tests. The DHS Information Line and the RIte Care Information Line also send the forms and the list of sites on request. Forms are also available from community health centers, certain hospitals, and other appropriate sites.

In addition to verification of pregnancy, all other eligibility criteria must be in place. Expedited eligibility is subject to the applicant meeting non-financial program requirements including third party liability requirements.

0348.35.10 Guaranteed Period of Eligibility

REV:10/2008

RITE CARE ELIGIBLE GROUPS

Individuals who attain eligibility due to a pregnancy are guaranteed eligibility for comprehensive services through two (2) months postpartum or post-loss of pregnancy and then are eligible for an Extended Family Planning benefit for up to an additional twenty-four (24) months, with a re-certification requirement at twelve (12) months, unless they remain eligible for the full scope of services.

NON-TITLE XIX RELATED GROUPS

The period of eligibility for Non-Title XIX Related Groups is determined by the individual Health Plan.

0348.40 COST SHARING

REV:06/2009

Some RIte Care participants pay for a portion of the cost of their health care coverage by paying a monthly premium and/or co-payments for certain services. The purpose of cost sharing is to promote more efficient and cost-effective utilization of services and to encourage program participants to assume some financial responsibility for their own health care. Program participants who fail to make required cost-sharing contributions may be denied a service or continuous Medical Assistance coverage in certain circumstances. However, non-payment of cost-sharing for emergency care, urgent care, or pregnancy-related services shall not prohibit access to necessary care or affect enrollment status of eligible Title XIX RIte Care Health Plan members.

Cost sharing requirements apply to all individuals whose countable family income equals or exceeds the following percentage of the federal poverty level income guidelines (FPL):

Children age one (1) year and under nineteen (19) years	150%
Families (parents/caretaker relative)	150%

EXCEPTIONS:

The following groups are exempt from cost sharing requirements:

- American Indian and Alaskan native children under the age of nineteen (19).
- Pregnant women
- Children under one (1) year of age.

RIte Care members may raise cost sharing appeals. Appeals related to non-emergency use of the emergency room or emergency transportation are first heard by the HMO. The recipient has the right to appeal the decision with the Department of Human Services through the Administrative Appeals process.

0348.40.05 Premium Share Requirements

REV:~~06/2009~~10/2011

The following individuals/groups must pay a monthly premium to maintain coverage:

1. MA Waiver Families with income equal to or greater than one hundred fifty percent (150%) of the federal poverty income guidelines (FPL) and not exceeding one hundred seventy-five percent (175%) of the FPL

2. Children age one (1) to nineteen (19) with family income equal to or greater than one hundred fifty percent (150%) of FPL, and not exceeding two hundred fifty percent (250%) of the FPL

3. Pregnant Women with family income above two hundred fifty percent (250%) of the FPL and not exceeding three hundred fifty percent (350%) of the FPL.

   The full State negotiated capitation rate will be billed to the pregnant woman by the health plan and in turn must be paid directly to the health plan by the pregnant woman.

4. Extended Family Planning recipients with family income above two hundred fifty percent (250%) of the FPL and not exceeding three hundred fifty percent (350%) of the FPL. The premium amount is determined as follows:

   - Pregnant women whose countable family income is above two hundred fifty percent (250%) but not exceeding three hundred fifty percent (350%) of FPL must pay the full State negotiated capitation rate to the health plan in addition to the schedule of point-of-service co-payments.

   - Extended Family Planning recipients whose countable Family income is above two hundred fifty percent (250%) but not exceeding three hundred fifty percent (350%) FPL must pay the full State negotiated Extended Family Planning premium for the particular health plan in addition to the schedule of point-of-service co-payments.

   - There is no premium charged for an individual whose MA eligibility is based on the federal poverty level Income standard for a family size of one, such as when an aunt applies for MA for her nephew only, or when an SSI parent with one child applies for MA for the child only.

   - There is no premium charged for RIW recipients, Extended MA recipients, IV-E and non IV-E foster children, or IV-E and non IV-E adoption assistance children.

   - For all others, the amount of the premium is d~~D~~etermined by countable family income as follows if:

Monthly Family Income	Family Premium
over 150% and not greater than 185% FPL	$ ~~61.00~~91.00
over 185% and not greater than 200% FPL	$ ~~77.00~~113.00
over 200% and not greater than 250% FPL	$ ~~92.00~~122.00

   - Monthly premiums are not prorated. Therefore, a full monthly premium is due if the family receives MA coverage for any portion of a coverage month.

0348.40.05.05 Non-Payment of Premiums

REV:10/2009

Individuals and families with countable income under 250% of FPL who are subject to cost sharing requirements must pay a monthly premium in order to maintain MA eligibility as follows:

1. For new MA applicants, no premium payment is required for: the month in which the MA application is received by DHS; or the month following the month of application. For purposes of this policy section, new MA applicant means an individual who did receive MA at any time during the month of application or the month before the month of application. (For an MA application filed 11/21, no premium is charged for November or December.) Depending upon when an application is received by the Department and when it is approved, a member could be responsible for a premium for a month in which they did not know that they were eligible.

2. A re-applicant is treated like a current recipient. See "CHANGES IN COST SHARING STATUS" below. For purposes of this policy section, a re-applicant means an individual who received MA benefits at any time in the month of application, or the month prior to the month of application.

3. Payment of the initial premium is due on the first of the month following the date of the initial bill. The initial bill will be sent during the first regular billing cycle following MA acceptance, and, depending on the date of MA approval, be for(1) or more months of premiums due.

4. Ongoing monthly bills will be sent to the individual or family approximately fifteen (15) days prior to the due date. Premium payments are due by the first (1st) day of the coverage month. (Payment for the month beginning 1/1 through 1/31 is due by 1/1.)

5. If full payment is not received by the twelfth (12th) of the month following the coverage month, a notice of MA discontinuance is sent to the individual or family. MA eligibility is discontinued for all family members subject to cost sharing at the end of the month following the coverage month. (If payment due on 1/1 is not received by 2/12, MA eligibility is discontinued effective 2/28.)

6. Dishonored checks and incomplete electronic fund transfers are treated as non-payments.

7. Individuals and families, who are discontinued for failure to pay a required premium are subject to a four (4) month restricted eligibility period, during which access to MA health coverage is denied. The restricted eligibility period applies to all members of the family financial unit who are subject to cost-sharing. It begins on the first of month after MA coverage ends and continues for four (4) full months. (If MA is discontinued effective 11/30, a restricted period of eligibility, during which MA is denied, will exist for the months of December, January, February and March sanctioned and disenrolled from MA coverage until balance is paid in full. Once balance is paid in full, sanction will be lifted and eligibility will be reinstated effective the first of the

month following the month of payment. If payment is made more than 30 days after the close of the case, in addition to the payment, a new application will be required.

8. DHS has the authority to recover Medical Assistance benefit overpayment claims and cost share arrearages through offset of the individual state income tax refund in accordance with Sections 44- 30.1-1, 44-30.1-3, 44-30.1-4 and 44-30.1-8 of the Rhode Island General Laws in Chapter 44-30.1 entitled 'Setoff of Refund of Personal Income Tax.' An example of a cost share arrearage is premium owed to the DHS by a beneficiary for a month in which Medical Assistance eligibility was active for at least one day.

See DHS policy section 0313 COLLECTION OF OVERPAYMENTS VIA STATE TAX REFUND OFFSET.

9. MA coverage shall be reinstated without penalty for otherwise eligible family members if all due and overdue premiums are received by the Department's fiscal agent on or before the effective date of MA discontinuance.

   An exemption may be granted in cases of good cause, as provided below.

   A restricted eligibility period may be shortened and MA eligibility re-established if: a) DHS determines that there was good cause for nonpayment of the premium and the individual remits all past due premiums; or b) the individual or family is no longer subject to cost-sharing requirements (e.g., family income decreases).Good cause means circumstances beyond a family's control or circumstances not reasonably foreseen which resulted in the family being unable or failing to pay the premium. Good cause circumstances include but are not limited to:

   o Serious physical or mental illness.

   o Loss or delayed receipt of a regular source of income that the family needed to pay the premium.

   o Good cause does not include choosing to pay other household expenses instead of the premium.

The state will also take action to collect premiums via tax offset as stated in Section 0313.

CHANGES IN COST SHARING STATUS

Medical Assistance recipients are required to report any changes, such as changes in income or family composition, which could effect the family's cost sharing status or premium share, within ten (10) days.

When such as change is reported in a timely manner, the following procedure is followed:

1. If the individual or family is moving from a "no cost sharing" status to a "cost sharing" status, no premium is due for the

month in which the change is reported or for the following month. These months are referred to as exempt months. (e.g. If an increase in income is reported timely on 12/15, and as a result of the increased income, the family is now subject to premium payments, no premium is due for the exempt months of December or January.)

The initial premium is due on the first of the month following the exempt months. A bill for the initial premium will be sent approximately fifteen (15) days prior to the due date. Future premiums are due on the first of the coverage month.

If the premium is not paid in full and received by the Department's fiscal agent by the twelfth (12th) of the month following the coverage month, a notice of MA discontinuance is sent to the individual or family. MA is discontinued effective the last day of the coverage month for any MA eligible members who are subject to cost sharing. MA benefits shall be reinstated without penalty if all due and overdue premiums are received by the Department's fiscal agent before the effective date of MA discontinuance. A four(4) month period of restricted eligibility is imposed if payment in full is not received before the effective date of MA discontinuance.

2. If the amount of the required premium is increasing, the old, lower premium is due for the month in which the change is reported and for the following month. Follow steps listed in #1 above.

3. If based on a change in circumstances, the amount of the premium is decreasing or individual or family is moving from "cost sharing" to "no cost sharing", the monthly premium is re-calculated effective the month the change occurred, or the month the change was reported or discovered, whichever is later. The individual's or family's bill is adjusted for the next regular billing cycle, and the case is evaluated to determine if, based on the change, any premiums not due were received by the Department. Any such payment received by the Department is applied to the family's past due premium bills, or refunded to the individual or family.

When a family does not report the change in circumstances within ten (10) days, the following procedure is used:

1. If the individual or family is moving from a "non cost sharing" status to a "cost sharing status", regular monthly premiums are due two months after the change is reported or discovered. (For example, if a family's reports in May that their income increased in January, the first regular monthly premium would be due on July 1st.) A monthly bill is sent to the individual or family approximately fifteen (15) days prior to the due date. If not paid by twelfth (12th) of the month following the coverage month, a notice of MA discontinuance is sent to any MA eligible family member(s) subject to cost sharing requirements. MA is reinstated if all due and overdue premiums are received before the effective date of MA discontinuance.

The case is then evaluated to determine the amount of premiums which would have been billed if the change was reported within the required ten (10) day time period. This amount is treated as an overpayment received by the individual or family, and referred to the Collections, Claims and Recovery Unit for collection in accordance with provisions contained in Section 0112 of the DHS Rules.

2. If the individual's or family's premium share is increasing, the increased premium is due two months after the change is reported or discovered. Follow additional steps shown in #1 above.

3. If based on a change in circumstances, the amount of the premium is decreasing or individual or family is moving from "cost sharing" to "no cost sharing", the monthly premium is re-calculated effective the month the change was reported or discovered. The individual's or family's bill is adjusted for the next regular billing cycle, and the case is evaluated to determine if, based on the date the change was reported or discovered, any premiums not due were received by the Department. An adjustment is not made, and no refund is issued for any premiums paid prior to the month the change was reported or discovered.

STATE FUNDED PREGNANT AND EFP WOMEN (250%-350% FPL)

Pregnant Women or Extended Family Planning Women whose incomes are above 250% but not exceeding 350% will be dropped from the RIte Care Program if they fail to make premium payments for three (3) consecutive months or if they habitually fail to make timely payments in accordance with health plan payment policies.

Although DHS will disenroll these members, the health plan has policies and procedures to:

- o notify the enrollee that failure to pay premiums will result in cancellation of coverage;

- o send notification thirty (30) days prior to the member's termination. This notice shall include information on how and when the past and current due premiums must be paid to avoid coverage termination;

- o notify DHS fifteen (15) days prior to the last day of the third month in which no payment is received.

The health plan may continue to seek payment of past due premiums from former members following their disenrollment. The health plans have written policies and procedures for past due premiums collection and must make these know to member at the time of enrollment.

0348.40.10 Co-Payment Requirements

REV:09/2010

State Funded Pregnant Women with income above two hundred fifty percent (250%) of the federal poverty level guidelines (FPL) and Extended Family Planning Recipients who have income above one hundred eighty-

five percent (185%) of FPL are required to make point-of-service copayments as listed below. Copayments are per person/per episode and are payable to the health care provider at the time of service.

State-funded Pregnant Women, Income 250%-350% FPL:

$ 5.00 - Office visits for all ambulatory encounters except for prenatal and preventative visits
$15.00 - Ambulatory surgical procedures
$ 2.00 - Prescriptions
$25.00 - Unauthorized non-emergency use of the emergency room
$35.00 - Non-emergency use of emergency transportation

Extended Family Planning,Regardless of Income Level:

$ 2.00 - Health care provider visits
$ 1.00 - Thirty (30) day supply of contraceptives
$15.00 - Voluntary sterilization procedures

0348.40.20 Collection Methods

REV:09/2010

The health plan has the responsibility for collecting premium payments directly from State Funded Pregnant Women and Extended Family Planning Recipients. The medical provider is responsible for any collecting copayments at the point-of-service delivery.

The health plan must not bill or attempt to collect any fee from, or for, a RIte Care member, except for the cost sharing amounts required. All premium and copayments collected for State Funded Pregnant Women (250%-350% FPL) and Extended Family Planning recipients belong to the health plan.

DHS is responsible for collecting premium payments for all other RIte Care members who are subject to cost sharing requirements.

DHS may collect premiums using any or all of the following methods:

- Electronic funds transfer (EFT)

  The eligible individual or family requests that their bank allow the state to withdraw the monthly premium directly from the family's savings or checking account by an electronic transfer to DHS. The family is given an EFT form to fill out. The funds will be withdrawn by the state on the third (3rd) day of the month prior to the month of coverage. The family will be notified by letter if the EFT premium payment was not successful.

- Wage withholding

  The recipient requests that their employer withhold the monthly premium from an employed member of the financial unit's paycheck. The employer will then pay the monthly premium to DHS through an EFT. The employed person is given a special form requesting wage withholding and deposit or transfer to take to his or her employer to be completed and mailed.

- Direct Pay

The individual or family pays the premium to DHS by check or money order every month. A premium payment coupon and pre-addressed envelope will be provided to the family before the premium is due. The check or money order and the premium payment coupon are mailed or delivered to the DHS fiscal agent. The recipient may choose to pay by Debit/Credit card or electronic check by phone or internet. Cash payments are also accepted at locations in the community

The medical provider is responsible for collecting copayments at the point-of-services delivery. The health plan must not bill or attempt to collect any fee from, or for, a RIte Care member, except for the cost sharing amounts required.

0348.40.30 Evidence of Insurability

REV:09/2010

Coverage is made available to individuals in Non-Title XIX Related Groups without evidence of insurability. Individuals who elect coverage through the Non-Title XIX related group are responsible for paying for their health coverage. The RIte Care Program does not contribute to the cost of coverage for these individuals. The Non-Title XIX Related recipients are outside of the actual RIte Care program. However, these individuals are allowed to participate, under the terms specified below, but are responsible for making full premium payments directly to health plan.

Participation is optional for these recipients:

1. CHILDREN WHO ARE UNDER 8 YEARS OF AGE WITH COUNTABLE INCOMES ABOVE 250% OF THE FPL

   These individuals are allowed to buy into the program without evidence of insurability by paying the full community rated non-group premium for the defined benefit package. Eligibility is verified by the applicant furnishing the health plan with the DHS notice of denial due to excess income. The health plan is permitted to deny service for lack of payment in the same manner as for its commercially enrolled members.

2. CONVERSION GROUP

   These are individuals who lose eligibility for the RIte Care program or individuals who are eligible for the Extended Family Planning benefit, but who choose to waive this benefit in favor of the conversion option. This group is offered a conversion benefit package by the health plan. Coverage, premium rates, and conversion terms and conditions are consistent with the conversion options offered by the health plans to their commercial and employer-sponsored enrollees.

   The health plan may restrict enrollment to all affected individuals within a family if more than one person is losing eligibility.

   The health plan is permitted to deny service to this group for lack of payment in the same manner as for its commercially enrolled members.

3. PREGNANT WOMEN WHOSE COUNTABLE INCOME EXCEEDS 350% FPL

These are uninsured or under-insured pregnant women whose countable income exceeds 350% of the FPL. The individuals are allowed to purchase care directly from the HMO without evidence of insurability, and with no exclusions of pre-existing conditions. The individual pays a monthly premium directly to the health plan. This premium includes the monthly negotiated capitation rate and the supplemental delivery payment. Eligibility is verified by the applicant furnishing the health plan with the DHS notice of denial due to excess income.

0348.45 RITE CARE BENEFITS

REV:09/2010

Under the RIte Care Program, the Title XIX eligible groups are entitled to all Title XIX covered services. The entitled services may be received either through the managed care plan or through the fee-for-service delivery system if the service is not included in the managed care plan. Fee-for-service benefits may be furnished either by the managed care provider or by any participating provider. Rules of prior authorization apply to any service requiring prior Departmental authorization.

The Extended Family Planning Group is entitled to family planning services.

Individuals who elect coverage through one of the Non-Title XIX related groups are responsible for making full premium payments and receive the services provided by the health plan.

Each individual selects a primary care physician (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care physician orders treatment he/she determines is medically necessary in accordance with HMO policies. Individuals in the Extended Family Planning (EFP) coverage group do not require a PCP.

Medical procedures of an investigative or experimental nature are not covered by the Medical Assistance Program and are therefore not included in the RIte Care program.

A service that is furnished for research purposes in accordance with medical standards is considered experimental or investigational. A procedure is determined to be investigative or experimental according to the current and historical judgment of the medical community as evidenced by medical research, studies, journals or treatises.

BENEFITS FOR RITE CARE ELIGIBLES

Rhode Island Works Program recipients, MAO family eligibles, children up to age nineteen (19) with countable family income not exceeding 250% of the FPL, and Title XIX pregnant women with countable family income above 175% but not exceeding 250% of the FPL are RIte Care covered groups entitled to the Comprehensive Benefit Package. State funded pregnant women with countable family income not exceeding 250% of the FPL are also eligible for the Comprehensive Benefit Package. State

funded pregnant women with countable family income not exceeding 350% of the FPL are eligible for the Comprehensive Benefit Package, in-plan services only.

Pregnant women are eligible for the appropriate Comprehensive Benefit Package (full or in-plan only) through delivery and two months postpartum or 60 days post-loss of pregnancy.

Title XIX RIte Care recipients are eligible for the full scope of Title XIX services whether in-plan or on a fee-for-service basis.

State funded RIte Care recipients are eligible for in-plan services only, except that State funded pregnant women with countable family incomes less than 250% of the FPL are eligible to receive medical services on a fee-for-service basis prior to their enrollment in a health plan, as described in Sections 0348.10.10.05 and 0348.40.30, and may receive out-of-plan benefits on a fee-for-service basis, as described in Section 0348.45.15.

In-plan services are paid for on a capitated basis (fixed cost per enrollee per month). The state, at its discretion, may identify other services (while they are in-plan benefits arranged for and provided by the health plan) paid for on a fee-for-service basis rather than at a capitated rate.

Out-of-plan services are paid for on a fee-for-service basis.

Sections 0348.45.05 through 0348.45.15 and Section 0348.55 describe the provisions which govern the following in-plan and out-of-plan services related to the RIte Care Program:

- o In-Plan Capitated Benefits
  - Comprehensive Benefit Package
  - Extended Family Planning Services
  - Severely and Persistently Mentally Ill (SPMI)
- o In-Plan Fee-for-Service Benefits
- o Out-of-Plan Benefits
- o Early Periodic Screening, Diagnosis and Treatment (EPSDT) Out-of-Plan Services

0348.45.05 In-Plan Capitated Benefits

REV:09/2010

The following are the benefits which the health plan provides or arranges within the capitated (fixed cost per enrollee per month) benefit. In-Plan Capitated Benefits are divided into the following three sections:

- o COMPREHENSIVE BENEFIT PACKAGE

  This benefit package is available to all Title XIX eligible participants (other than Extended Family Planning, SPMI, or SED individuals as defined below), and State funded pregnant women with countable family income less than 250% of the FPL. State funded RIte Care eligibles with countable family income

exceeding 250% of the FPL receive only the in-plan benefits.

- o EXTENDED FAMILY PLANNING

  This restricted benefit package is available for a 24 month period from sixty (60) days postpartum to twenty six (26) months postpartum to women who attained Medical Assistance eligibility by virtue of pregnancy.

- o SPMI
  Adults who are found to be Severely and Persistently Mentally Ill (SPMI) receive the Basic Benefit Package, subject to modifications described in Section 0348.45.05.10.

0348.45.05.05 Comprehensive Benefit Package

REV:09/2010

The following benefits are included in the capitated rate:

SERVICE	SCOPE OF BENEFIT (ANNUAL)
Inpatient Hospital Care	Up to 365 days per year based on medical necessity*
Outpatient Hospital Services	Covered as needed based on medical necessity. Includes physical therapy, occupational therapy, and speech, hearing and language services.
Physician Services	Covered as needed based on medical necessity. Includes surgical services including reconstructive surgery as medically necessary. Second surgical opinion to an in network or out of network physician, as ordered by a plan physician.
Family Planning Services	Family Planning Services, including family planning counseling, are available to eligible men and women. The Comprehensive Benefit package includes benefits described in the Extended Family Planning Benefit Package (see Section 0348.45.05.10) with the exception of certain non-prescription family planning materials which are not in the current Medicaid covered benefits, as follows: foam, condoms, and spermicidal jelly.
Prescription Drugs	Covered when prescribed by a health plan physician. For RIte Care enrolled members, prescription benefits shall be for generic drugs. Exception for limited brand coverage for certain therapeutic classes shall be granted if approved by the

	Department of Human Services, or the Managed Care Organizations acting in compliance with their contractual agreements with DHS, and in accordance with the criteria described below.

For purposes of approving exceptions to generic-first drug coverage for medical assistance recipients, the Department of Human Services will determine certain Allowed Brand Name Therapeutic Classes/Single Agents drugs. DHS will consider the following characteristics of the drug and the clinical conditions under which it is prescribed for purposes of exceptions to generic-first:

Review criteria for approval of exceptions to generic-first will include:

1. Availability of suitable within-class generic substitutes or out-of-class alternatives.
2. Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.
3. Relative disruptions in care that may be brought on by changing treatment from one drug to another.
4. Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.
5. Relative clinical advantages and disadvantages of drugs within a therapeutic class.
6. Cost differentials between brand and generic alternatives.
7. Drugs that are required under Federal and State regulations.
8. Demonstrated medical necessity and lack of efficacy on a case by case basis.

Non-Prescription Drugs	Covered when prescribed by a health plan physician, limited to non-prescription drugs covered by Rhode Island Medical Assistance Program.
Laboratory Services	Covered when ordered by a health plan physician.
Radiology Services	Covered when ordered by a health plan physician.
Diagnostic Services	Covered when ordered by a health plan physician.
Mental Health and Substance Abuse Services	Including drug screens when medically necessary and sexual abuse counseling.
Outpatient	
Mental Health and Substance Abuse Services	Including day treatment and Inpatient Partial hospitalization.
Residential Treatment	Residential substance abuse treatment for adolescents thirteen (13) to

	seventeen (17) years of age or residential treatment ordered by the Department of Children, Youth, and Families are out-of-plan benefits.
Methadone Maintenance and Outpatient Services	Methadone Detox as ordered by a health plan physician.
EPSDT Services	Provided to all children and young adults up to age 21, according to the EPSDT periodicity schedule. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, follow-up vision, hearing, and dental visits. Includes interperiodic screens as medically indicated. Includes multidisciplinary evaluation and treatment for children with significant developmental disabilities or developmental delays. Plan Capitated for Benefit for all EPSDT Services except those specifically described in ESPDT out-of-plan services. See Section 0348.55.
Court Ordered services	To an in-network provider.
Early Intervention Services	Center based health and education programs for children at risk for being developmentally delayed.
Certified Home Health Agency Services (short-term acute)	Provided as ordered by a health plan physician. (Short-term acute includes all medically necessary home health services with the exception of home health care provided in lieu of care in a nursing facility.)
Post-Stabilization Care	As medically necessary and as ordered by a physician in an urgent or emergency care setting.
Emergency Room Services, and Emergency Transportation Services Covered based on	Emergency services are not covered when provided outside of the United States.

the prudent lay (ambulance) Person definition.

* At this time, plans may not impose copayments for "non-emergency use of the emergency room or emergency transportation" on those plan members whose countable family income falls below 185% of the FPL.

Nursing Facility Services	Medically necessary skilled nursing care in an appropriately licensed nursing facility when ordered by a

	health plan physician.
Private Duty Nursing	Covered if ordered by a health plan physician.
Services of Other Practitioners*	Covered if referred by a health plan physician.

* Practitioners, certified and licensed by the State of Rhode Island including nurse practitioners, physician assistants, social workers, licensed dieticians, psychologists, and licensed nurse midwives.

School Based Health Centers	As referred by primary care physician (PCP).
Podiatry Services	Provided as ordered by health plan physician
Optometry Services	Routine visits are self referral. For adults 21 and older, benefit is limited to examinations that include refractions and eyeglass dispensing, once every two years, and any other medically necessary treatment visits for illness or injury to the eye. For children under 21, covered as medically necessary with no other limits.
Durable Medical Equipment	Provided as ordered by a health plan physician. Includes Surgical Appliances, Prosthetic Devices, Orthotic Devices, and Medical Supplies. Includes hearing aids and molded shoes.
Hospice Services	Up to 210 days lifetime maximum as ordered by a health plan physician. Services limited to those provided by Medicare.
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as defined in the Health Plan RFP and as referred by a health plan physician.
Group Education/Programs	These services are self-referral. Including childbirth education classes, parenting classes, and smoking cessation programs.
Non-Emergency Transportation Services	Responsibility for transportation rests first with the recipient. If the recipient's condition, place of residence, or location of medical provider does not permit the use of

	bus transportation, non-emergency transportation for a Medicaid client may be arranged for by DHS or its agent for transportation to a Medicaid covered service from a Medicaid participating provider. Covered non-emergency transportation services may include bus passes, Rhody Ten Ride passes, RIPTIKS, other RIPTA fare products and also includes RIPTA paratransit vans and taxi services, if authorized by DHS or its agent. The health plan provides emergency medical transportation to its members as part of their prepaid benefit.
Interpreter Services	During the enrollment process, DHS will attempt to identify RIte Care enrollees who speak a language other than English as their first language. DHS will notify the health plan when it knows of members who do not speak English as a first language who have either selected or been assigned to the plan. If the health plan has more than fifty members who speak a single language, it must make available general written materials, such as its member handbook, in that language. Interpreter services are covered if a plan has more than 100 members or 10% of its RIte Care membership, whichever is less, who speak a single language other than English as a first language. The plan must develop appropriate methods for communicating with its visually and hearing impaired members and for accommodating the physically disabled. Health plans will be required to conform with standards outlined in the Americans with Disabilities Act (ADA).
Tracking, Follow-up, and Outreach	Tracking, Follow-up, and Outreach for an initial visit with member's PCP; for preventive visits and prenatal visits; referrals that result from preventive visits; and for preventive dental visits. Outreach includes

	mail, phone, and home outreach, if necessary, for members who miss preventive and follow-up visits, and to resolve barriers to care such as language and transportation barriers.
Organ Transplant Services	As described in Section 0300.20.05 and 0300.20.05.25, Organ Transplant Operations.

For all Medical Assistance recipients under age 21, EPSDT requires coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct defects and physical and mental illnesses and conditions discovered through screening or at any other occasion, whether or not those services are covered by the State Medicaid plan.

The following services do not require a PCP referral:

- Mental Health/Substance Abuse services
- Sterilization, Family Planning Services
- Parenting, Prenatal and Smoking Cessation group education
- Routine Eye Exams

*For purposes of this policy section, the term "medical necessity" or "medically necessary service" means medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health related condition including such services necessary to prevent a decremental change in either medical or mental health status. Medically necessary services must be provided in the most cost-efficient and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

0348.45.05.10 In-Plan Benefits for the SPMI

REV:09/2010

SPMI Adults will have access to a modified Comprehensive Benefit Package. The Comprehensive Benefit Package will be the responsibility of the health plan with the exception of all mental health services which will be "out-of-plan". That is, mental health services for these groups are not in the capitated benefit, and are not the responsibility of the health plan to provide, arrange, or pay for. These services will be provided on a fee-for-service basis by Medicaid-approved mental health providers. In-patient mental health services and emergency room visits for psychiatric emergencies will be out-of-plan as well.

It is the responsibility of the plan to assure coordination and communication between in-plan service providers and out-of-plan mental health service providers.

Substance abuse treatment services for these groups will be in-plan subject to the limitations of the basic benefit package.

0348.45.05.15 Extended Family Planning Benefits

REV:09/2010

Women who attain eligibility for Medical Assistance due to a pregnancy and who become ineligible for the full scope of services 60 days postpartum or post-loss of pregnancy continue to remain eligible for RIte Care for a period of up to twenty-four (24) months for the Family Planning benefit package. The benefit package includes interpreter services but does not include transportation benefits. Re-certification is required at 12 months.

Women who are otherwise eligible for Medical Assistance are eligible for family planning services as delineated in Section 0348.45.05.05.

Participation in this service is voluntary. However all participants continue to be enrolled with the plan for up to a twelve (12) month period unless they re-qualify for Medical Assistance, move out-of-state, or die. Persons who qualify for this benefit remain with the same health plan they selected or were assigned to for comprehensive health service delivery.

Upon re-certification at twelve (12) months, a participant may qualify for up to an additional twelve (12) months.

Services are covered on an outpatient basis only.

Inpatient services are not a covered benefit for the Extended Family Planning population, except as medically necessary follow-up treatment of a complication from provision of a covered procedure or service. The Extended Family Planning Group benefit package includes:

- o Gynecological Services
  (Limited to no more than four (4) office visits annually:
  One (1) comprehensive gynecological annual exam and up to three (3) additional family planning method related office visits if indicated);

- o Laboratory:
  Annual Pap smear;
  STD screening if indicated;
  Anemia testing;
  dipstick urinalysis and urine culture if indicated;
  Pregnancy testing;

- o Procedures-
  (Covered benefit is limited to the following office/clinic/ outpatient procedures if indicated):
    - tubal ligation;
    - treatment for genital warts;
    - Norplant insertion and removal;
    - IUD insertion and removal;
    - incision and drainage of a Bartholin's gland cyst or abscess;

- o For RIte Care enrolled members, generic-first prescriptions with the exception of limited brand drug coverage for certain therapeutic classes as approved by the Department of Human Services, and non-prescription family planning methods (Limited to 12 30-day supplies per year) are covered when prescribed by a health plan physician.

  Covered contraceptives include oral contraceptives,

contraceptive patch, contraceptive vaginal, contraceptive implant, contraceptive IUD, contraceptive injection, cervical cap, diaphragm, and emergency contraceptive pills, when prescribed by a health care physician. Covered non-prescription methods include foam, condoms, spermicidal cream/jelly, and sponges;

- o Referrals for other medically necessary services as appropriate/indicated, including: referral to State STD clinic for treatment if indicated; referral to State confidential HIV testing and counseling sites, if indicated.

0348.45.05.20 Communities of Care

REV:09/2010

A. The primary goal of Communities of Care (CoC) is to improve access to care and promote member involvement in their care in an effort to decrease non-emergent and avoidable Emergency Department (ED) utilization and associated costs.

B. The target population for CoC are Medicaid recipients who utilize the ED four (4) or more times during the most recent twelve (12) month period. CoC is available to RIte Care eligibles without other health insurance coverage (e.g., commercial, Medicare, etc.). Members will be notified of the requirement to participate in CoC. This notification will include program overview, responsibilities, all applicable appeal rights and duration of services. The DHS reserves the right to make exceptions to CoC participation when clinically appropriate.

C. CoC will consist of the following core components:
   1. Health Service Utilization Profile
   2. Identification for and Assignment to Restricted Provider Network (i.e. "Lock-In) or Select Provider Referral
   3. Member Outreach and Engagement
   4. Assessment for Care Management and/or Peer Navigator
   5. Development and Implementation of Personal Incentive/Reward Plan

0348.45.05.20.05 Health Service Utilization Profile

REV:09/2010

The Department of Human Services (DHS) or its contracted Managed Care Organization (MCO) will create a health services utilization profile for each CoC member based on the services used and determine whether the member is eligible for the Restricted Provider Network or the Select Provider Referral.

0348.45.05.20.10 Identification for Restricted Provider Ntwrk

REV:09/2010

CoC members who demonstrate one or more of the following utilization patterns/practices within a consecutive 180-day period will be enrolled in the Restricted Provider network of CoC:
   1. ED visits with three (3) or more different Emergency Departments in a consecutive 180-day period;

2. Utilization of four (4) or more different PCP's in a consecutive 180-day period;
3. Utilization of three (3) or more different Behavioral Health Providers in a consecutive 180-day period;
4. Prescriptions at six (6) or more different pharmacies in a consecutive 180-day period;
5. Received controlled substances from four (4) or more different providers in a consecutive 180-day period;
6. A medical billing history during past 180 days that suggests a possible pattern of inappropriate use of medical resources (e.g. conflicting health care services, drugs, or supplies suggesting a pattern of risk);
7. Other relevant patterns that emerge during the utilization profile.

0348.45.05.20.15 Assignment to Restricted Provider Network

REV:09/2010

A. CoC members selected for the Restricted Provider Network (lock-in) shall select the following providers:
   1. One PCP
   2. One Pharmacy
   3. One Narcotic Prescriber and/or Psychiatric Medication Prescriber (as appropriate based on Health Utilization Profile and case review)
   4. One or more mental health and/or substance abuse providers, as appropriate.

B. CoC members identified for the restricted provider network (lock-in) shall only receive their primary care, narcotic prescription care, pharmacy and behavioral health care from the single provider selected by the member for each of the four provider types noted above.

C. A member may be exempt from assignment to the Restricted Network when clinically appropriate as determined by DHS or its MCO Medical Director based on further review of the member's health service utilization profile.

D. Members will be notified of their right to appeal enrollment in the Restricted Provider Network (Lock-In).

0348.45.05.20.20 Select Provider Referral

REV:09/2010

CoC members eligible for the Select Provider Network are those who have a complex medical condition or chronic disease and are not assigned to a Restricted Provider Network (lock-in). CoC members who use multiple providers and have one or more complex medical conditions and chronic diseases (e.g. diabetes, chronic obstructive pulmonary disorder, heart failure, asthma, generalized anxiety disorders, depression) shall be referred to the Select Provider Network. The Select Provider Network shall contain providers who have experience serving the elderly, disabled adults, and those with chronic diseases and multiple complex medical conditions.

0348.45.05.20.25 Member Outreach and Engagement

REV:09/2010

DHS or its contracted MCO shall conduct outreach to eligible CoC members to identify reasons why the recipient opts to utilize the Emergency Department for a non-emergent condition, and how that utilization can be avoided in the future. This includes both avoidance of unnecessary ED utilization and improved connections with care providers to help avoid acute episodes and improve management of chronic conditions. During outreach, DHS or its contracted MCO shall review the CoC program and the member's rights and responsibilities. This includes explanation of the restricted provider network or the select provider referral and the associated appeal rights.

0348.45.05.20.30 Care Management / Peer Navigator

REV:09/2010

Recipients identified for enrollment in CoC shall be assigned a care manager who will assist the client in developing an individualized care plan. CoC members may be referred to a peer navigator. The role of the peer navigator is to assist the CoC member in reducing barriers to care, to access medical and non-medical resources and to assist the member throughout the care coordination and treatment process.

0348.45.05.20.35 Dev. and Implementation of Personal Rewards

REV:09/2010

Individualized Incentive Plans will be developed for each CoC member consistent with the individual's Care Plan in order to reward specific behaviors and achievements consistent with the CoC Program.

The Incentive Plans will be developed by the member's Care Manager and/or Peer Navigator, in conjunction with the member. Members shall be able to select their incentives and rewards, based on a prescribed menu of options, to assure meaningfulness to the reward program. Examples of possible incentives or rewards include gift cards, digital thermometers or recognition events.

0348.45.05.20.40 Completion of CoC Program Enrollment

REV:09/2010

Completion of participation in CoC will occur when:

1. care plan objectives are achieved;
2. recipient experiences loss of Medicaid eligibility; or
3. after a minimum of 12-months in the CoC program.

0348.45.10 In-Plan Fee for Service Benefits

REV:01/2002

The health plan or its approved providers will bill the Medical Assistance Program fee-for-service for Medical Assistance (MA) covered in-plan benefits that have not been included in the capitated rate.

0348.45.15 Out-of-Plan Benefits

REV:01/2002

Out-of-plan benefits are not included in the capitated benefit and are not the responsibility of the health plan to provide or arrange.

These services are provided by existing Medicaid-approved providers who are reimbursed directly by Medical Assistance on a fee-for- service basis.

The out-of-plan benefits which are provided to eligible groups are set forth below. All RIte Care Enrollees are eligible for these services, except for the following groups: 1) those eligible only for Extended Family Planning; 2) those state-funded pregnant and post-partum women with family income above two hundred fifty percent (250%) of FPL; and 3) those enrolled in the guaranteed enrollment period but otherwise ineligible for MA (Section 0348.35.10).

- Court-ordered services to out-of-network providers;
- Residential Substance Abuse treatment services for adolescents (thirteen (13) to seventeen (17) years old);
- Routine Dental Services (Emergency Dental Services are In-plan);
- Family Planning Services. RIte Care recipients may seek family planning services either in-plan or from an out-of-plan provider. If they seek these services in-plan, the plan must provide them as part of its capitated benefit package and may not bill the State fee-for-service. However, members are permitted to self-refer. For those individuals who elect to go out of network due to issues or concerns related to confidentiality, the plan will reimburse the provider on a fee-for-service basis.

Children are provided:

- Non-medical case management for Head Start children;
- Home visits for assessment and follow-up of Level I screenings (Family Outreach Program);
- School-based health services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays;
- Lead Program home assessment/intervention and nonmedical case management provided by the Department of Health for children with lead poisoning;
- Home Based Treatment Services;
- CEDARR Services.

Seriously and Persistently Mentally Ill Adults & Seriously Emotionally Disturbed Children are provided:

- Juvenile Drug Court Case Management Services (provided by Case Care Coordinators (CCP)).

0348.50 DHS OUT-OF-PLAN PROGRAMS

REV:01/2002

The RI Department of Human Services (DHS) operates a number of other programs to address the health and social needs of persons who may be enrolled in RIte Care. Health Plans and RIte Care families are urged to make use of these programs if they qualify.

For information about DHS programs, contact DHS at 462-5300 (462-3363 TDD/TTY for hearing impaired).

0348.55 EPSDT OUT-OF-PLAN SERVICES

REV:01/2002

For all Medical Assistance recipients under age 21, EPSDT requires coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct defects and physical and mental illnesses and conditions discovered through screening, or at any occasion. Such medically necessary diagnosis and treatment services must be provided regardless of whether such services are covered by the State Medical Assistance Plan, as long as they are MA-covered services as defined in the Social Security Act.

The health plan must assure that all medically necessary, MA-covered diagnosis and treatment services are provided, either directly or by referral. However, if the services are neither covered by the State Medical Assistance Plan nor included in the capitated benefit package, the health plan may bill the State fee-for-service.

These services include:

- Chiropractic
- Christian Science services
- Other services that are medically necessary (as determined and prior authorized by the state) to treat or ameliorate a condition that is discovered during an EPSDT screen.

0348.60 NON-COVERED SERVICES

REV:09/2010

The following services are not covered under the RIte Care Program:

- Experimental procedures, except as required by RI state law;
- Abortion services, except to preserve the life of the woman, or in cases of rape or incest;
- Private rooms in hospitals (unless medically necessary);
- Cosmetic surgery;
- Infertility treatment services;
- Services of Institutions for Mental Diseases (IMD) for individuals age 21 - 65. (The Waiver allows IMDs to provide services to individuals age 21-64 years under HMO contracts when such services are a direct substitute for inpatient services provided to an individual in a distinct part psychiatric unit of a general acute hospital. In the RIte Care Program, IMD services will only be covered if the recipient is enrolled with a health plan.;
- Specific HCPCS codes not covered under the state plan, as defined in the Rhode Island Medical Assistance Program Fee

Schedule.

0348.65 PROVIDER NETWORKS

REV:01/2002

The health plan must maintain provider networks in geographically accessible locations for the populations to be served, comprised of hospitals, physicians, mental health providers, substance abuse providers, pharmacies, transportation services, dentists, school based health centers, etc. in sufficient numbers to make available all services in a timely manner.

0348.65.05 Mainstreaming / Selective Contracting

REV:09/2010

The mainstreaming of Medical Assistance beneficiaries into the broader health delivery system is an important objective of the RIte Care program. The health plan therefore must ensure that all of its network providers accept RIte Care members for treatment.

The health plan also must accept responsibility for ensuring that network providers do not intentionally segregate RIte Care members in any way from other persons receiving services.

Health Plans may develop selective contracting arrangements with certain providers for the purpose of cost containment, but must still adhere to the access standards as defined in the health plan contracts.

0348.65.10 Primary Care Providers (PCPs)

REV:01/2002

The health plan has written policies and procedures for allowing every member to select a primary care provider (PCP). The PCP serves as the member's initial and most important point of interaction with the health plan network. In addition to performing primary care services, the PCP coordinates referrals and specialty care. As such, PCP responsibilities include at a minimum:

- Serving as the member's primary care provider;
- Ensuring that members receive all recommended preventive and screening care appropriate for their age group and risk factors;
- Referring for specialty care and other medically necessary services both in- and out-of-plan;
- Maintaining a current medical record for the member;
- Adhering to the EPSDT periodicity schedule for members under age 21.

Although PCPs are given responsibility for the above activities, the health plan also retains responsibility for monitoring PCP actions to ensure they comply with health plan and RIte Care program policies.

Services to which RIte Care members may self refer are:

- Family Planning Services
- Routine Eye exams
- Mental Health Services
- Substance Abuse Services
- Sterilization
- Parenting skills, Prenatal and Smoking Education

0348.70 SERVICE ACCESSIBILITY STANDARDS

REV:07/1994

The service accessibility standards which the health plan must meet are:

- Twenty-four-hour Coverage;
- Travel Time;
- Days to Appointment for non-emergency Services.

In addition, health plans must staff a Member Services function and a Provider Services function.

0348.70.05 Twenty Four Hour Coverage

REV:07/1994

The health plan must provide coverage, either directly or through its PCPs, to members on a twenty-four hours per day, seven days a week basis. The health plan also has written policy and procedures describing how members and providers can contact it to receive instruction or prior authorization for treatment of an emergent or urgent medical problem.

0348.70.10 Travel Time

REV:07/1994

The health plan must make available to every member a PCP whose office is located within twenty minutes driving time from the member's place of residence. Members may, at their discretion, select PCPs located farther from their homes.

0348.70.15 Appointment for Non-Emergency Services

REV:01/2002

The health plan must make services available within twenty-four hours for treatment of an urgent medical problem. The plan must make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days.

Non-emergent, non-urgent mental health or substance abuse appointments for diagnosis and treatment must be made available within five (5) business days.

The term "urgent" medical problem means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four hours could reasonably be expected to result in:

a. Placing the patient's health in serious jeopardy;

b. Serious impairment to bodily function; or,

c. Serious dysfunction of any bodily organ or part.

0348.70.20 Member Services

REV:07/1994

The health plan must staff a Member Services function operated at least during regular business hours and responsible for the following:

- Explaining the operation of the health plan and assisting members in the selection of a PCP;
- Assisting members to make appointments and obtain services;
- Arranging medically necessary transportation for members;
- Handling members' complaints.
- Toll-free telephone number

  The health plan must maintain a toll-free Member Services telephone number. While the full Member Services function is not required to operate after regular business hours, this or another toll-free telephone number must be staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and weekends.

0348.70.25 Provider Services

REV:07/1994

The health plan must staff a Provider Services function operated at least during regular business hours and responsible for the following:

- Assisting providers with questions concerning member eligibility status;
- Assisting providers with plan prior authorization and referral procedures;
- Assisting providers with claims payment procedures;
- Handling provider complaints.

0348.75 RITE CARE ENROLLMENT

REV:09/1998

Subsections 0348.75.05 through 038.75.75 contain policies governing enrollment in a RIte Care health plan, including enrollment counseling and assistance to participants, health plan selection, automatic assignment to a health plan, changing health plans and other related matters.

0348.75.05 Enrollment Process

REV:01/2002

The enrollment process insures that applicants/recipients:

1) Are provided with materials describing the managed care program;
2) Are provided with information about each of the health plans (HMOs) from which individuals or families make a selection, including, when requested, information regarding which plan their physician is participating in and a health plan comparison chart;
3) Are provided with an enrollment form on which a family chooses a health plan and instructions on how to complete it;
4) Are informed of the ways to make a choice of health plan;
5) Are notified in writing of the time limit in which to choose a health plan;
6) Are notified in writing that they may contact DHS to request an interpreter, if needed;
7) Are notified in writing of the right to challenge auto-assignment for good cause through the Center for Child and Family Health (See DHS Manual Section 0348.75.05.20).

When the combined application is used, applicants/recipients have fourteen (14) calendar days to select a health plan and complete an enrollment form. If a selection is not made within 14 days after their eligibility determination is completed, individuals will be automatically assigned to a plan. At the end of 14 days, applicants/recipients who have not selected a plan will be notified in writing that an automatic assignment has taken place and they will be notified of the plan to which they have been assigned.

The short form (MARC-1) application incorporates the enrollment form, and accompanying materials in the application packet detail the applicant's managed care options. If the applicant fails to select a health plan on the short form but all other information necessary for eligibility is present, the family will be automatically assigned to a plan.

0348.75.05.05 Non-Biased Enrollment Counseling

REV:01/2002

Non-biased (i.e. not affiliated with a particular health plan) enrollment counselors are available to all RIte Care eligibles.

Enrollment counselors are located full-time at the larger and part-time at the smaller DHS District Offices during regular hours of operation

as well as at other eligibility sites. They also are available in person and by telephone to assist RIte Care enrollees who would like to change health plans (e.g., during open enrollment or due to good cause).

Non-biased enrollment counselors help participants to choose a managed care provider in accordance with the patient's needs, e.g., current medical provider, language, or geographic proximity.

0348.75.05.10 RIte Care Info Line

REV:10/2008

The RIte Care Information Line (Info Line), telephone 462-5300, is a statewide toll-free service to provide access to program information to all potential RIte Care eligibles. This service is also accessible through the R.I. Department of Health Telecommunication Device for the Deaf, TDD/TTY # 222-2506. The function of the Info Line is to:

- Provide basic program information to potential RIte Care eligibles such as how and where to apply;
- Provide basic information to members, such as how to access health plan services;
- Answer questions from RIte Care enrollees and, if appropriate, direct members to their health plan for assistance;
- Answer enrollment and disenrollment questions;
- Accept and resolve or triage complaints from RIte Care enrollees.

0348.75.05.15 Voluntary Selection of Health Plan

REV:01/2002

RIte Care eligibles are given fourteen (14) calendar days from the completion of their eligibility determination to select a health plan. All members of a family must select the same health plan. If an individual or family does not select a health plan within the time allowed, the individual or family is automatically assigned to a health plan.

0348.75.05.20 Automatic Assignment into Health Plan

REV:09/2010

The State employs a formula, or algorithm, to assign to health plans all RIte Care eligibles who do not make a voluntary selection. This algorithm considers quality and financial performance.

Eligible individuals, who have been auto-assigned to a RIte Care health plan due to their failure to make an independent selection, may be re-assigned to a different RIte Care health plan of their choice, if their written request for reassignment and choice of plan is received by the DHS Center for Child and Family Health (CCFH) within ninety (90) days of the auto-assignment and the plan selected is open to new members.

Eligible individuals, who wish to challenge an auto-assignment decision more than ninety (90) days after enrollment in the health plan must submit a written request to CCFH and show good cause, as provided in Section 0348.75.20, for reassignment to another plan.

A written decision must be rendered by CCFH within ten (10) days of receiving the written request and is subject to appeal.

0348.75.05.25 Auto Re-Assign, Following Resumption of Elig

REV:09/2010

Members of RIte Care families who are disenrolled from a health plan due to loss of eligibility are automatically re-enrolled, or assigned, into the same plan should they regain eligibility within sixty (60) calendar days. If more than sixty (60) days have elapsed, the family is permitted to select a plan from those open for enrollment at that time.

The State employs a formula, or algorithm, to assign to health plans all RIte Care eligibles who do not make a voluntary selection. The state may choose to employ an algorithm that considers quality and financial performance.

0348.75.05.30 ENROLLMENT PROCESS FOR CHILDREN W/S.H.C.N.

REV:09/2010

All Medical Assistance beneficiaries who meet the criteria for enrollment as a child with special health care needs (as per Section 0348.10.05), will receive written communications from DHS that explains the program to the beneficiary and the choice of a managed care organization (MCO). A reasonable timeframe is allowed for the beneficiary to make a decision regarding their health plan choice.

The beneficiary is enrolled into a participating MCO as the beneficiary has indicated. If a beneficiary does not respond within the timeframe the individual shall be enrolled and assigned an MCO.

The Non-CSHCN family members must remain enrolled in the same health plan as the child with special care needs.

0348.75.10 Enrollment of Newborns

REV:01/2002

Newborns born to Title XIX or State Funded eligible mothers with income less than 250% of FPL who are enrolled in a health plan on the date of their baby's birth are automatically enrolled into the mother's health plan, effective on the date of birth, upon notification of the birth. Legally adopted children shall be enrolled as of the date the adoption becomes final. This date cannot be prior to the date Medical Assistance eligibility is established.

DHS may be notified of the birth through various means. A parent or guardian of the infant may notify DHS directly, or the birth hospital or the mother's health plan may notify the agency.

Newborns born to women in the state-funded coverage group with income greater than two hundred fifty percent (250%) are not presumed eligible for MA or automatically enrolled in the RIte Care Health Plan.

The birth hospital may issue a hospital birth record to the mother and forward a copy of hospital birth record to the agency.

The birth record is a reliable alternative for evidence of birth.

Refer to section 0342.40.10.05 or 0346.25.10.05 for information relative to the hospital birth record.

For a mother in managed care, the birth hospital notifies the health plan of the birth event. Upon notification by the hospital, the health plan will, within 5 days, forward a Health Plan Status Change Reporting Form (RC-80HP) to the Center for Child and Family Health (CCFH).

Upon being notified of a birth, the Eligibility Technician or RIte Care Worker will notify the mother in writing that she needs to contact the agency within 30 days to complete a revised application and to comply with other eligibility requirements, e.g., to file an SS-5 form for the newborn.

A child born to a woman eligible for and receiving Medical Assistance on the date of the child's birth is deemed:

- To have filed an application and been found eligible for Medical Assistance on the date of birth; and,

- To remain eligible for one year provided that:

  - the child resides continuously in the mother's household;

  - the mother remains eligible for Medical Assistance or would have remained eligible if she were still pregnant.

If at any time it is determined that the mother would not remain eligible if she were still pregnant, or that the infant is not residing in the mother's household, the infant loses her/his deemed eligibility forever. At this time, the infant's eligibility for medical coverage on any other basis would need to be determined.

Enumeration is a requirement of eligibility for the newborn.

However, failure to enumerate the child results in a sanction against the mother, not the child. The child will remain eligible even if lacking a social security number because of mother's failure to cooperate. The sanction against the mother is loss of her eligibility for failure to cooperate. This sanction will be removed once mother meets the enumeration requirements.

0348.75.15 Partial Month Enrollment

REV:01/2002

DCYF has the continuing responsibility to notify the MA Foster Care Unit of any change in circumstances for the Foster or Group Care child.

The change in circumstance could be a change in placement or a change in the child's income or resources.

When a child is no longer in the agency's care, notification and return of the medical identification card is made to the Division of Health Care Quality, Financing and Purchasing, 600 New London Avenue, Cranston, RI 02920.

If a child is returned to his family, the agency worker informs the family about Medical Assistance. If the family is potentially eligible, the worker helps the family apply for MA coverage.

0348.75.20 Exemption from Enrollment

REV:01/2002

Foster children under the age of twenty-one (21) shall be exempted from health plan enrollment upon request of the Department of Children, Youth and Families (DCYF).

Individuals in families eligible for Medical Assistance in RIte Care aid categories may be exempted from health plan enrollment only when an individual requests an exemption due to "extraordinary circumstances," and the Center for Child and Family Health (CCFH) approves the request.

CCFH will exempt a recipient from health plan enrollment only if the exemption request is due to the existence of extraordinary circumstances that preclude the individual from receiving medically necessary care through any RIte Care health plan. For purposes of exemption from health plan enrollment, "extraordinary circumstances" may include:

- The existence of an unusual and life-threatening medical condition that requires medical treatment no health plan can provide or arrange for; or,

- The existence of a chronic, severe medical condition for which the recipient has a longstanding treatment relationship with a provider who does not participate with any RIte Care health plan.

- An individual's preference to continue a treatment relationship with a doctor or other health care provider who does not participate with an available RIte Care health plan does not constitute an "extraordinary circumstance" in and of itself.

Enrollment exemptions requested due to extraordinary circumstances must be in writing, with appropriate documentation (letter from physician, medical records, or other as indicated), and signed by the recipient or caretaker relative. Exemption requests should be routed to CCFH.

CCFH makes enrollment exemption determinations based on a consideration of the circumstances of each individual's request.

Once exempted, an individual can be exempt for as long as the extraordinary circumstance exists. Non-exempt family members must follow the normal RIte Care health plan enrollment process.

Individuals whose incomes are 250% of the FPL and above (State-Funded Groups, Related Groups, and Extended Family Planning Only Groups) receive health care services only via enrollment in a health plan. No fee-for-service benefits are provided to such individuals under any circumstances, regardless of health plan enrollment status: therefore, no exemptions will be granted for these groups.

0348.75.25 Mandatory Participation in Managed Care

REV:09/2010

Participation in managed care is mandatory for Rhode Island Works (RIW) recipients and Title XIX family recipients, with the exception of disabled or flex-test eligibles, are enrolled. Participation in managed care is also mandatory for children with special health care needs, as described in RIte Care Coverage Groups Section 0348.10.05.

Upon application for the RIW Program or Title XIX benefits, applicants waive the right to freedom of choice of medical provider.

However, whenever possible, the applicant receives non-biased enrollment counseling to select a health plan which includes the family's present health care provider.

Enrollment in managed care health care delivery systems is mandatory for individuals eligible for medical assistance. This includes children in substitute care, children receiving Medical Assistance through an adoption subsidy, and children eligible for medical assistance based on their disability, as described in RIte Care Coverage Groups Section 0348.10.05. Beneficiaries with third-party medical coverage or insurance may be exempt from mandatory managed care at the discretion of the Department of Human Services.

"Managed care" is defined as systems that integrate an efficient financing mechanism with quality service delivery; provide a "medical home" to assure appropriate care and deter unnecessary services; and place emphasis on preventive and primary care.

0348.75.30 Health Plan Lock-In

REV:01/2002

Following their initial enrollment into a plan, RIte Care families are restricted to that plan until the next open enrollment period, unless disenrolled under one of the allowed conditions.

Recipients in the guaranteed period of eligibility may request disenrollment for any of the following reasons:

a. Poor quality of care;
b. Lack of access to necessary specialty services;
c. Lack of access to transportation;
d. Discrimination;
e. Moving;
f. Good Cause;
g. Without cause during the ninety (90) days following the effective date of the individual's initial enrollment with the health plan.

Health plan members seeking disenrollment during the lock-in period must first file a formal appeal pursuant to grievance and appeal procedures with the health plan. Disenrollment can only be ordered by the Center for Child and Family Health (CCFH) after administrative review of the facts of the case. In order for disenrollment to occur, the CCFH must first find in favor of the member, and then determine that the appropriate resolution to the member's complaint is the member's disenrollment.

If, based upon the evidence submitted by the health plan, CCFH determines that the individual should be disenrolled from their current health plan, a notice advising of same shall be sent ten (10) days prior to the date the proposed disenrollment would be effective.

If disenrollment from the health plan is the result of this process, the recipient must meet with the enrollment counselor to select another health plan.

0348.75.35 Open Enrollment

REV:01/2002

During open enrollment individuals have an opportunity to newly select or to change health plans. Open enrollment includes all RIte Care participants except individuals covered for the Extended Family Planning benefit.

0348.75.40 New Member Informational Meetings

REV:07/1994

Plans are required to hold informational "welcome" meetings for new members at least once a month. Such meetings must be offered at two different times of day, including an evening session, to ensure that the majority of new enrollees have an opportunity to attend.

Interpreter services are provided to the extent such provision is reasonable and practical, given the number of enrollees speaking a particular language.

0348.75.45 Membership Handbook

REV:01/2002

Once an individual is enrolled, the HMO provides, by mail and within ten (10) days (fifteen (15) days for foster care children), a membership handbook and information on how to select a primary care physician.

0348.75.50 Identification Cards

REV:01/2002

A TEMPORARY identification card issued by the HMO is also included with the membership handbook when it is sent by mail within the ten days of enrollment. Until the temporary identification card is received, the health plan will allow members to access care by presenting their DHS letter of acceptance, which is proof of the recipients eligibility for Medical Assistance.

Health plans issue PERMANENT identification cards to all RIte Care and Related Group members within forty-five (45) days of enrollment. (Health plans are not required to issue a temporary identification card if a permanent identification card is issued within ten (10) days of enrollment, or within fifteen (15) days of enrollment for foster care children.) The card identifies the plan name and a twenty-four hour, toll-free telephone number for the recipient to call in the event of an urgent or emergent health care problem. The card also includes the telephone number for the plan's membership services division and the name and telephone number of the recipient's primary care physician.

A Medical Assistance identification card is also issued to RIte Care eligibles who are eligible for out-of-plan benefits. The Medical Assistance identification card is used to access out-of-plan se

0348.75.55 InRHODES and MMIS Systems

REV:10/1997

Department of Human Services (DHS) eligibility technicians and social caseworkers receive, review and process applications.

Eligibility data is entered into InRhodes, the Department's automated eligibility system. When eligibility is established, recipient eligibility data is electronically transferred through an interface onto the Department's Medicaid Management Information System (MMIS).

Once a plan is selected, the individual enrollment information is entered into the MMIS which interfaces with InRhodes to process the enrollment. Health plan enrollment or assignment information is provided on a daily basis to the health plans electronically.

The individual's enrollment information is sent to the plan along with the daily roster updates within one business day of the health plan assignment. Health plans have a seven (7) day period between health plan assignment and plan enrollment. Any covered service delivered to the recipient by any Medical Assistance provider from the first date of their eligibility until enrollment in a health plan, including this seven (7) day period, is paid on a fee-for-service basis.

Services delivered prior to plan enrollment to a State funded pregnant woman with countable family income greater than 250% of the FPL are not covered by MA/RC.

Individuals requiring services immediately contact their selected health plan which, in turn, verifies enrollment by telephoning the Recipient Eligibility Verification System (REVS). The health plan has the responsibility to provide services immediately upon enrollment into the health plan.

0348.75.60 Responsibility to Report Change in Status

REV:07/1994

Individuals are responsible for reporting certain changes in status such as family size, residence, income, and employment. A status change form must be filed with the DHS Eligibility and Enrollment Unit within 10 days of any changes, such as income, address, other health

insurance coverage or living arrangements. In addition, the Eligibility and Enrollment Unit staff will conduct periodic reviews of client files to determine whether any change in status has occurred. Health plans will also be required to report any change in status as they become aware of such changes.

0348.75.65 Redetermination of RIte Care Eligibility

REV:05/1999

For MAO families and other RIte Care eligibles with incomes not exceeding 250% of the FPL, redeterminations of eligibility are made whenever a significant change occurs or is expected to occur and at least once every twelve (12) months. A face-to-face interview is required at the time of redetermination if the short form (MARC-1) is not used.

0348.75.70 Conversion Option

REV:05/1997

Individuals who lose eligibility for the RIte Care program are offered a conversion option plan by HMOs under contract to the State. Such coverage and premium rates, as well as conversion conditions, must be consistent with the conversion option products offered by the plans to their commercial and employer sponsored enrollees. The health plan may restrict enrollment to all affected individuals within a family, if more than one person is losing eligibility.

0348.75.75 Transitioning Members Between Plans

REV:07/1994

It may be necessary to transition a member between health plans for a variety of reasons, including a change in health plan during open enrollment or a change that is ordered as part of a grievance resolution. The health plans have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when transitioning a member to or from another plan. The health plan must transfer this information at no cost to the member.

0348.80 GRIEVANCE AND APPEALS

REV:07/1994

The State provides a Grievance and Appeals process through which providers and members can seek redress against health plans, and through which health plans can seek to disenroll members who are habitually non-compliant or who pose a threat to plan employees or other members.

0348.80.05 Complaint Resolution

REV:07/1994

The health plans resolve member and provider complaints through internal mechanisms whenever possible. The health plans therefore maintain written policies and procedures for resolving member complaints and for processing grievances when requested by the member

or provider, or when the time allotted for complaint resolution expires. (See section 0348.80.10 for timeliness.)

0348.80.10 Timeliness

REV:07/1994

The health plan may take up to fifteen (15) days to seek resolution of a medical care related complaint and may take up to thirty (30) days to seek resolution of a non-medical care related complaint.

If a complaint is not resolved to the satisfaction of the member or provider within the allotted time, the health plan must agree to automatically register the complaint as a formal grievance, unless requested otherwise by the member or provider. The health plan also must agree to register a complaint as a formal grievance if requested to do so at any time by the member or provider, even if the fifteen (15) or thirty (30) day limit has not been reached.

In addition, the health plan must comply with the initial and second level appeals process as described in Rhode Island's Rules and Regulations for the Utilization Review of Health Care services.

0348.80.15 Formal Grievances

REV:09/2010

The health plans maintain internal policies and procedures to conform to State reporting policies and provide a process for logging formal grievances.

RIte Care members must exhaust the internal health plan appeals process before requesting a DHS Fair Hearing.

Appeals filed with a Health Plan fall into three (3) areas:

1. Medical Emergency - A Health Plan must decide the appeal within two (2) business days when a treating provider, such as a doctor who takes care of the member, determines the care to be an emergency and all necessary information has been received by the Health Plan.
2. Other Medical Care - There are two (2) levels of a non-emergency medical care appeal.
   a. For the initial level of appeal, the Health Plan must decide the appeal within fifteen (15) days of all necessary information being received by the Health Plan. If the initial decision is against the member, then the Health Plan must offer the second level of appeal.
   b. For the second level of appeal, The Health Plan must decide on the grievance within fifteen (15) days of all necessary information being received by the Health Plan.
3. Non-Medical Care - If the grievance involves a problem other than medical care, the Health Plan must decide the grievance within thirty (30) days and all necessary information has been received by the Health Plan.

RIte Care members may also choose to initiate a third (3rd) level or external appeal, per the Department of Health Rules and Regulations for the Utilization Review of Health Care Services (R23-17.12-UR). A member

does not have to exhaust the third level appeal before accessing the DHS fair hearing process.

RIte Care members must exhaust the internal health plan appeals process before requesting a DHS Fair Hearing.

Regulations governing the appeals process are found in Section 110 of the General Provisions of the DHS Manual.

0348.80.20 Grievance Initiated Disenrollments

REV:09/2010

The health plan may seek disenrollment of a member if he or she is habitually non-compliant or poses a threat to health plan employees or other members. Examples of habitually non-compliant members would include but not necessarily be limited to those who:

- Present a clear and present danger to the employees and/or other members of the health plan.

A health plan initiated disenrollment, is subject to an administrative review process at the Center for Child and Family Health (CCFH).

In order for a plan to disenroll a member they must send a request, along with accompanying documentation, to CCFH. When the request is received, the CCFH sends a notice to the member informing them that the plan is seeking their disenrollment and the reason given by the plan for the action. The notice also informs the member that they have the right to submit evidence establishing good cause within ten (10) days. CCFH investigates and renders a decision within ten (10) days of receipt of evidence from both parties. The decision is subject to appeal.

If, based upon the evidence submitted by the health plan, CCFH determines that the individual should be disenrolled from their current health plan, a notice advising of same shall be sent to the member ten (10) days prior to the date the proposed disenrollment would be effective.

A RIte Care eligible individual whose disenrollment is being requested has the right to present evidence establishing good cause.

Good cause must be filed prior to the end of the ten (10) day advance notice period. The filing of good cause is submitted in writing to CCFH or to the RIte Care worker or eligibility technician to whom the case is assigned who will forward it to the CCFH.

Good cause includes circumstances beyond the participant's control such as illness of the participant or of another family member sufficiently serious to require the presence of the participant; an unanticipated household emergency; a court-required appearance; incarceration; breakdown in transportation arrangements; and inclement weather which prevented the participant and other persons similarly situated from traveling to, or participating in, the required appointment. A member's preference to remain in fee-for- service Medical Assistance does not constitute good cause for an appeal or request for disenrollment.

A record of the individual's justification for good cause must be kept in the case log; the decision and the reasons for that determination must also be documented in the case log.

Decisions on good cause claims must be rendered by CCFH within ten (10) days of the receipt of evidence from all parties.

If disenrollment from the health plan is the result of this process, the recipient must meet with the enrollment counselor to select another health plan.

0348.85 MEMBER DISENROLLMENT

REV:01/2002

GENERAL AUTHORITY

DHS has sole authority for disenrolling RIte Care members from health plans, subject to the conditions described in Sections 0348.85.05 and 0348.85.10. The health plan has sole authority for disenrolling members from Related Groups. (See Section 0348.85.25).

Request for disenrollment, either as the result of a formal grievance filed by the member against the health plan, or by the health plan against the member, is subject to an administrative review process by the Center for Child and Family Health (CCFH).

CCFH will decide whether to grant or deny the request based on the circumstances of the individual case.

If, based upon the evidence submitted by the health plan, CCFH determines that the individual should be disenrolled from their current health plan, a notice advising of same shall be sent ten (10) days prior to the date the proposed disenrollment would be effective.

0348.85.10 Reasons for Disenrollment

REV:09/2010

DHS may disenroll RIte Care members from a health plan for any of the following reasons, but may not be limited to:

- death
- Loss of eligibility;
- Selection of another health plan during open enrollment;
- Change of residence outside of the plan's service area;
- Non-payment of premium share;
- Incarceration
- Permanent placement in Eleanor Slater Hospital
- Placement in a nursing facility for more than thirty (30) days;
- Disenrollment as the result of a formal grievance filed by the member against the health plan; or,
- Disenrollment as the result of a formal grievance filed by the health plan against the member.

In the instance of the last two types of disenrollment, either at the request of the member or the health plan, CCFH must conduct an administrative review of the facts of the case and render a decision within ten (10) days of receipt of evidence from both parties.

0348.85.15 Disenrollment Effective Dates

REV:07/1995

Member disenrollments outside of the open enrollment process become effective on the date specified by the State, but not fewer than six (6) days after the health plan has been notified, unless the health plan waives this condition. The health plans have written policies and procedures for complying with State disenrollment orders.

0348.85.25 Non-Title XIX Related Group

REV:07/1994

Individuals who qualify for coverage as part of a Non-Title XIX Related Group shall be subject to the same premium collection and coverage termination provisions as other non-group (individual) subscribers to the plan. The health plans have written policies and procedures for premium collection and coverage termination.

These must be made known to members at the time of enrollment.

0348.85.35 Notification of Disenrollment

REV:07/1994

All notifications of disenrollment must include information regarding the recipients right to appeal the decision and the procedure for requesting a hearing.

0348.85.40 Departmental Hearings

REV:09/2010

Rhode Island Works (RIW) Program and Title XIX recipients have the right to an appeal with the Department of Human Services but must exhaust the internal health plan appeals process before requesting a DHS Fair Hearing. (See Section 0110 of the General Provisions of the DHS Rules).

0348.90 PATIENT'S RIGHTS AND PROTECTIONS

REV:01/2002

All RIte Care patients are guaranteed access to quality health care delivered in a timely and respectful manner. To ensure this goal the following rights and protections must be clearly stipulated.

A. Enrollment
   1. DHS will make every effort to provide multilingual services to all people who do not speak English.

   2. Written enrollment information will be provided in a clear and easy to understand format.

   3. Enrollment information provided by the plan must include detailed information on how to obtain transportation services, second opinions, interpreter services, referrals, emergency services and out of state services unavailable in Rhode Island. Information must also be provided regarding

switching primary care providers, disenrollment for good cause, the in-plan grievance process and the DHS appeals process.

4. The State will conduct a special enrollment outreach effort for beneficiaries who are homeless or who live in transitional housing.

5. The HMO, once a client is enrolled, will conduct a special enrollment outreach effort for beneficiaries who are homeless or who live in transitional housing.

6. The HMOs will be prohibited from doing any door-to-door or telemarketing or any other similar unfair marketing practices.

7. Enrollees will be provided with counseling assistance in the selection process for their primary care providers.

8. RIte Care beneficiaries who receive on-going care from a primary care provider or specialist will be advised by the non-biased enrollment counselor which providers are participating in each HMO so as to promote continuity of care.

9. If patients are assigned to an HMO they may dispute that assignment through the right to rebuttal. A decision by CCFH must be rendered within ten (10) days of the filing of the rebuttal and is subject to appeal. (See DHS Manual Section 0348.75.05.20.)

B. Second Opinions and Switching Doctors

1. Health plans should provide, at their expense, a second opinion within the health plan upon enrollees request. A decision on the request for a second opinion will be made in a timely manner and approval shall not be unreasonably withheld.

2. Health plans should provide a second opinion by a qualified, non-participating provider when the plan determines that an enrollee's chemical dependency or mental health problem does not require treatment.

3. A RIte Care member is entitled to a second surgical opinion by a plan physician, or if the referral is made by a plan physician, to a second surgical opinion by a non-participating physician

4. Patients have the right to switch providers within the plan, upon request. Reasons for switching providers would include the following:
   a. Substandard care;
   b. Problems with language or communication;
   c. Discrimination;
   d. Rude treatment or personality conflicts with providers or provider staff;
   e. Moving;
   f. Good Cause.

5. Members who are denied a second opinion or denied the right to switch providers will have the right to appeal under the Grievance Procedures as listed below.

C. Grievance Procedures

1. Patients have the right to appeal the following decisions:
   a. Assignments to providers;
   b. Referrals;
   c. Denial of services;
   d. Determinations of non-emergency care.

2. Patients have the right to a timely in-plan grievance procedure.

3. Patients have the right to a timely fair hearing from the Department of Human Services. (See Section 110 of the General Provisions of the DHS Manual).

4. Grievances filed with HMOs that relate to medical treatment must be decided within fifteen days.

D. Disenrollment

1. Patients may request to disenroll from any HMO during the remainder of any enrollment period when it is established that any of the following exists:
   a. Poor quality of care;
   b. Lack of access to necessary specialty services;
   c. Lack of access to transportation;
   d. Discrimination;
   e. Moving;
   f. Good cause;
   g. Without cause.

   Health plan members seeking disenrollment during the lock-in period must first file a formal appeal pursuant to grievance and appeal procedures with the health plan (with the exception that members are permitted to disenroll without cause during the ninety (90) days following the effective date of the individual's initial enrollment). Disenrollment can only be ordered by CCFH after administrative review of the facts of the case. In order for disenrollment to occur, CCFH must first find in favor of the member, and then determine that the appropriate resolution to the member's complaint is the member's disenrollment.

2. A rapid disenrollment process must be provided for families or beneficiaries who are dislocated and move to another area due to homelessness, domestic abuse, or other similar crises, if they cannot access in-plan services within a reasonable distance from their new location.

3. Patients who are disenrolled have a right to appeal that decision through the DHS appeals process.

E. Interpreter Services

1. Plans are encouraged to provide availability to twenty-four

(24) hour interpreter services for every language group enrolled by the HMO for all points of contact, especially telephone contact.

2. Reasonable attempts will be made to have written materials, such as forms and membership manuals, translated into other languages. If the health plan has more than fifty (50) members who speak a single language, it must make available general written materials, such as its member handbook, in that language. Interpreter services are provided if a plan has more than one hundred (100) members or ten percent (10%) of its RIte Care membership, whichever is less, who speak a single language other than English as a first language.

F. Exceptions Based on Safety Needs
Providers, health plans and the State shall consider the personal safety of a client in instances of domestic violence in all of the following matters:
1. Enrollment policies;
2. Disenrollment policies;
3. Second opinions;
4. Switching primary care providers;
5. Grievance procedures.

G. Referral to Rhode Island Legal Services
Notices to recipients include the information that if you request a hearing you may represent yourself or be represented by someone else such as a lawyer, relative, or another person. Notices also include information regarding free legal help being available by calling Rhode Island Legal Services.