

**State of Rhode Island and Providence Plantations**

**Executive Office of Health & Human Services**



**Access to Medicaid Coverage Under the Affordable Care Act**

**Section 1310:**

**Rhody Health Partners**

**For MACC Group Adults – 19 to 64**

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**Rhode Island Executive Office of Health and Human Services**  
**Access to Medicaid Coverage Under the Affordable Care Act**  
**Rules and Regulations Section 1310:**  
**Rhody Health Partners for MACC Group Adults – 19 to 64**

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## ***Introduction***

These rules related to Access to Medicaid Coverage Under the Affordable Care Act, Section 1310 of the Medicaid Code of Administrative Rules entitled, “Rhody Health Partners for MACC Group Adults – 19 to 64” are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et. seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

## **1310 Rhody Health Program**

### **1310.01 Overview**

Rhody Health Partners (RHP) is a managed care delivery system for Medicaid eligible adults. Participants in Rhode Health Partners (RHP) are enrolled in a managed care organization (MCO), a type of health plan which uses a primary care provider to coordinate all medically necessary health care services through an organized delivery system. The Medicaid agency contracts with MCOs to provide these health services to members at a capitated rate or fixed cost per enrollee per month.

Adults eligible under this rule who have access to a Medicaid approved employer-sponsored health insurance plans are evaluated for participation in the RIt Share Premium Assistance Program and are required to enroll in an employer plan approved by the Medicaid agency as a condition of retaining Medicaid eligibility.

### **1310.02 Scope and Purpose**

Effective on January 1, 2014, Rhode Island is implementing a new eligibility system for individuals and families seeking affordable coverage funded in whole or in part by Medicaid, tax credits and/or other public subsidies. The new system uses a single standard – modified adjusted gross income (MAGI) – to determine income eligibility for affordable coverage across populations. To facilitate the transition to the MAGI, the RI Medicaid agency has reconfigured these populations into four distinct Medicaid affordable care coverage groups (MACC GROUPS): families, pregnant women, children and adults without dependent children. (See Medicaid Code of Administrative Rules (MCAR) Section 1301.03). Eligible members of the MACC group for adults without dependent children will be enrolled in a RHP health plan or, as applicable, RIt Share. The purpose of this rule is to describe the RHP delivery system for members of this MACC group and the respective roles and responsibilities of the Medicaid agency and the individuals receiving affordable coverage through RHP.

### **1310.03 Applicability**

Effective January 1, 2014, the provisions governing RHP for persons who are eligible for Medicaid on the basis of being aged, blind, or with a disability are located in MCAR Section 0374.

### **1310.04 Definitions**

**“Communities of Care (CoC)”** means the special delivery system that provides more intensive care management within a limited network to Medicaid members enrolled in either RIt Care or Rhody Health Partners who have Emergency Department utilization rates at or above the threshold for participation set by the Medicaid agency.

**“Managed Care Organization (MCO)”** means a health plan system that integrates an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and place emphasizes preventive and primary care.

**“Medicaid Affordable Care Coverage (MACC) Group”** means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014 as follows:

- (01) Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.
- (02) Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child’s citizenship and residence is the basis for eligibility.
- (03) Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.
- (04) Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

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

**“Medically Needy”** means a classification of persons eligible to receive Medicaid based upon similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

**“Member or enrollee”** means a Medicaid-eligible person receiving benefits through a RIte Care managed care organization.

**“New Applicant”** means an individual or family that was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date of this rule. The term does not apply to individual and families who were receiving coverage and where disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

**“Non-MAGI Coverage Group”** means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

**“Prudent Lay Person Standard”** means the standard used to determine the need for an emergency room visit. An “emergency” is defined as a condition that a prudent lay person “who possesses an average knowledge of health and medicine” expects may result in: (1) placing a patient in serious jeopardy; (2) serious impairment of bodily function; or (3) serious dysfunction of any bodily organs.

**“Rhody Health Partners”** means the Medicaid managed care program that delivers affordable health coverage to eligible adults without dependent children, ages 19 to 64, under MCAR section 1311 and adults with disabilities eligible under section 0374.

**“Rite Care”** means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age 19, and young adults older than age 19 (see section 1309 of the Medicaid Code of Administrative Rules).

**“Rite Share”** means the Medicaid premium assistance program for eligible individuals and families who have access to cost-effective commercial coverage.

**“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:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

### **1310.05 MACC Group in Rhody Health Partners**

The MACC group participating in RHP is adults, ages 19 to 64, who are not: pregnant, entitled to received Medicare Part A or B, or otherwise eligible for or enrolled in a Medicaid State Plan mandatory coverage group. (See MCAR Section 1301.05(05)).

### **1310.06 Overview of RHP**

Individuals enrolled in RHP receive the full scope of services covered under the Medicaid State Plan and the State’s Section 1115 waiver, unless otherwise indicated. Covered services may be provided through the managed care plan or through the fee-for-service delivery system if the service is “out-of-plan” – that is, not included in the managed care plan but covered under Medicaid. 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 required by Medicaid agency. Each RHP member selects a primary care physician (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care physician orders treatment determined to be medically necessary in accordance with MCO policies.

01. Access to Benefits – Unless otherwise specified, MACC group adults coverage groups entitled to a comprehensive benefit package that includes both in-plan and out-of-plan services. In-plan services are paid for on a capitated basis. The State may, at its discretion, identify other services paid for on a fee-for-service basis rather than at a capitated rate.

02. Delivery of Benefits – The coverage provided through the RHP is categorized as follows:

- In-Plan Capitated Benefits, including: RHP Comprehensive Benefit Package; Special Services for Severely and Persistently Mentally Ill (SPMI)
- In-Plan Fee-for-Service Benefits
- Out-of-Plan Benefits

03. Medical necessity – The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered services is required and appropriate. A "medically necessary service" means medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health related condition including any such services are 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 must not be provided solely for the convenience of the member or service provider.

**1310.07 RHP In-Plan Capitated Benefits**

The following are the benefits which the health plan provides or arranges within the capitated (fixed cost per enrollee per month) benefit. In-Plan benefits subject to the capitated rate are organized into categories two categories: the RHP comprehensive benefit package and the special benefit package for persons qualifying for coverage as severely and persistently mentally ill (SPMI). Adults who are found to be severely and persistently mentally ill receive the basic benefit package, subject to modifications described in section 1310.07.02, until July 2014.

01. RHP comprehensive benefit package --The following benefits are included in the capitated rate on an annual basis, based on medical necessity:

<i>RHP – In-Plan Comprehensive Benefit Package</i>	
<i>Service/Benefit</i>	<i>Scope of Coverage</i>
<b>Inpatient hospital care</b>	Up to 365 days

***RHP – In-Plan Comprehensive Benefit Package***

<b><i>Service/Benefit</i></b>	<b><i>Scope of Coverage</i></b>
<b>Outpatient hospital services</b>	Includes physical therapy, occupational therapy, and speech, hearing and language services
<b>Physician services</b>	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
<b>Family planning services</b>	Services include family planning counseling (available to eligible men and women) and services
<b>Prescription medications</b>	Covered in compliance with the Medicaid agency's generic drug policy (see section 1310.07.01.01)
<b>Non-prescription drugs</b>	When prescribed by a health plan physician, limited to non-prescription drugs identified as covered by the Medicaid agency
<b>Laboratory, radiology and diagnostic services</b>	When ordered by a health plan physician
<b>Behavioral health services</b>	Includes drug screens, substance abuse services necessary and sexual abuse counseling
<b>Outpatient behavioral health</b>	Includes day treatment and inpatient substance abuse services and partial hospitalization
<b>Methadone maintenance and methadone detox</b>	As ordered by an outpatient services health plan physician
<b>Certified home health agency as ordered by a health plan services (short-term acute)</b>	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
<b>Post-stabilization care</b>	As ordered by a physician in an urgent or emergency care setting
<b>Emergency room services and transportation when provided outside of the State based on the prudent lay person standard</b>	Services provided in accordance with the prudent layperson standard. See definition in section 1309.04. Must be provided in the United States
<b>Nursing facility services</b>	In an appropriately licensed nursing facility when ordered by a health plan physician
<b>Private duty nursing licensed nurse midwives</b>	As ordered by a health plan physician
<b>Services of other health practitioners – includes practitioners, including any practitioners, certified and licensed by the State such as nurse practitioners, physician assistants, social workers, licensed dieticians, psychologists, and licensed nurse midwives</b>	If referred by a health plan physician
<b>Podiatry services</b>	As ordered by health plan physician
<b>Optometry services</b>	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
<b>Durable medical equipment</b>	As ordered by a health plan physician. Includes surgical appliances, prosthetic devices, orthotic devices, medical supplies, hearing aids and molded shoes
<b>Hospice services</b>	As ordered by a health plan physician. Services limited to those provided by Medicare
<b>Nutrition services</b>	As referred to licensed dietitian by a health plan physician for certain medical conditions
<b>Group education/programs</b>	On a self-referral basis including childbirth education classes, parenting classes, and smoking cessation programs

<i>RHP – In-Plan Comprehensive Benefit Package</i>	
<i>Service/Benefit</i>	<i>Scope of Coverage</i>
<b>Non-emergency transportation</b>	In accordance with section 1310.07.01.02
<b>Interpreter services</b>	For enrollees who speak a language other than English as their first language as described in section 1310.07.01.03
<b>Organ transplant services</b>	As described in Section 0300.20.05 and 0300.20.05.25, Organ Transplant Operations
<b>Tracking, follow-up and outreach</b>	In accordance with section 1310.07.01.04

Medicaid agency policy affects the access to and/or the scope and amount of several of these benefits as follows:

- (01) Prescriptions: Generic Policy. For RHP enrolled members, prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by the Medicaid agency, or the MCO acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below:
  - Availability of suitable within-class generic substitutes or out-of-class alternatives.
  - Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.
  - Relative disruptions in care that may be brought on by changing treatment from one drug to another.
  - Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.
  - Relative clinical advantages and disadvantages of drugs within a therapeutic class.
  - Cost differentials between brand and generic alternatives.
  - Drugs that are required under federal and State regulations.
  - Demonstrated medical necessity and lack of efficacy on a case by case basis.
- (02) Non-emergency transportation policy. Responsibility for transportation services rests first with the member. If the member's condition, place of residence, or the location of medical provider does not permit the use of bus transportation, non-emergency transportation for the Medicaid enrollee may be arranged for by EOHHS or its agent for transportation to a Medicaid covered service from a Medicaid participating provider. Includes bus passes, Rhody Ten Ride passes, RIPTIKS, other RIPTA fare products and also includes RIPTA paratransit vans and taxi services, if authorized by EOHHS or its agent.
- (03) Interpretation services policy. EOHHS 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.

(04) Tracking, Follow-up, Outreach. These services are provided by the health plan in association with 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.

02. Special SPMI modifications – SPMI adults have access to a modified comprehensive benefit package. All elements of the comprehensive benefit package are the responsibility of the health plan with the exception of certain behavioral health services. For members of this population, such services are "out-of-plan" -- that is, not included in the capitated benefit -- and not the responsibility of the health plan until July 2014. In the interim, behavioral health services are provided, instead, on a fee-for-service basis by Medicaid-approved providers. In-patient mental health services and emergency room visits for psychiatric emergencies are also out-of-plan. It is the responsibility of the plan to assure coordination and communication between in-plan service providers and out-of-plan behavioral health service providers. Note: Substance abuse treatment services for these groups will be in-plan subject to the limitations of the basic benefit package.

### **1310.08 In-plan Fee-For-Services Benefits**

The health plan or its approved providers will bill the Medicaid agency for fee-for-service for Medicaid State Plan and Section 1115 waiver covered in-plan benefits that have not been included in the capitated rate.

### **1310.09 Out-of-Plan Benefits**

Out-of-plan benefits are not included in the capitated rate 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 the Medicaid agency on a fee-for-service basis. Out-of-plan benefits are provided to all RHP enrollees with the following exceptions: anyone enrolled in the guaranteed enrollment period but otherwise ineligible for Medicaid. The covered benefits are as follows:

- Court-ordered services to out-of-network providers;
- Routine dental services (emergency dental services are in-plan);
- Family planning services. RHP recipients may seek family planning services either in-plan or from an out-of-plan provider. When members 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, the plan will reimburse the provider on a fee-for-service basis;

- Seriously and Persistently Mentally Ill Adults & Seriously Emotionally Disturbed Children are provided Juvenile Drug Court Case Management Services (provided by Case Care Coordinators (CCP)).

### **1310.10 Communities of Care**

The Medicaid agency has established a special service delivery system within both RItE Care and Rhody Health Partners managed care plans called the Communities of Care (CoC). The goal of the CoC is to improve access and promote member involvement in care in an effort to decrease non-emergent and avoidable Emergency Department (ED) utilization and associated costs. The target population or CoC are Medicaid members who utilize the ED four (4) or more times during the most recent twelve (12) month period. RItE Care members will be notified of the requirement to participate in CoC. Section 1314 of the MCAR sets forth the requirements of the CoC for MACC group eligible individuals and families, including those enrolled in RItE Care.

### **1310.11 Services that are Not Covered By Medicaid**

01. Non-covered services --The following services are not covered under the Medicaid 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; and
- Services of Institutions for Mental Diseases (IMD) for individuals age 21 – 65 in fee-for-services. RHP managed care enrollees may access IMDs.

02. Out-of-State Coverage --The Medicaid agency does not provide coverage for out-of-state services with two exceptions: Medicaid services provided in border communities are covered and emergency services are covered, within limits, at the discretion of the Medicaid agency.

### **1310.12 Scope of Provider Networks**

The health plan must maintain provider networks in locations that are geographically accessible to 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.

### **1310.13 Mainstreaming / Selective Contracting**

The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of the Medicaid agency. The health plan must ensure that all of its network providers accept RHP members for treatment. The health plan also must accept responsibility for ensuring that network providers do not intentionally segregate RHP 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.

### **1310.14 Primary Care Providers (PCPs)**

The health plan has written policies and procedures 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; and

In addition, the health plan retains responsibility for monitoring PCP actions to ensure they comply with health plan and Medicaid program policies.

### **1310.15 Service Accessibility Standards**

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 both a member services and provider services function and a Provider Services function.

01. Twenty-Four Hour Coverage--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 must also have available 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.
02. Travel Time --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.
03. Appointment for Non-Emergency Services --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.
04. Member Services -- 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; and
  - Toll-free telephone number.

The health plan must maintain a toll-free member services telephone number. Although 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.

05. Provider Services - 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; and
  - Handling provider complaints.

### **1310.16 Mandatory Participation in Managed Care**

Participation in managed care is mandatory for the members of the MACC, non-MAGI and non-Medicaid funded coverage groups identified in section 1309.06, except as specified in section 1311.07. Medicaid members in these coverage groups with third-party medical coverage or insurance may be exempt from this mandate only as indicated in section 1311.07, at the discretion of the EOHHS.

### **1310.17 Enrollment Procedures, Rights, and Responsibilities**

The enrollment process for MACC groups using the RHP delivery system is set forth in MCAR section 1311.

### **1310.18 Information and Referral**

#### **For Further Information or to Obtain Assistance**

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

- [www.eohhs.ri.gov](http://www.eohhs.ri.gov)
- [www.dhs.ri.gov](http://www.dhs.ri.gov)
- [www.HealthSourceRI.com](http://www.HealthSourceRI.com)

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-447-7747.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

### **1310.19 Severability**

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.