

0302 The Application Process

October 2013

Applicability. The provisions in this section do not apply to the individuals and families in the Medicaid affordable care coverage (MACC) groups identified in MCAR section 1301 that take effect on January 1, 2014. The rule governing the application process for the Medicaid affordable coverage groups included in section 1301 are located in MCAR section 1303. **Accordingly, the provisions in this rule pertaining to individuals and families in the MACC groups outlined in section 1301 apply only to those who were enrolled and receiving Medicaid coverage prior to January 1, 2014, as specified.**

0302.05 The Request for Medicaid

Repealed October 2013

Section 0302 The Application Process

0302.05.05 The Request for A Medicare Part D Application

Repealed October 2013

0302.10 Contents of the Application Packet

REV: October 2013

For persons seeking Medicaid eligibility under sections 0351, 0374, 0375, and 0378, the application packet consists of the following documents:

<i>Individuals/Couples/QMB'S/QDWI'S</i>
DHS-1 Application Form/
DHS-2 Statement of Need
MA Booklet
DHS-14 Office Locations
QMB-2 Information for QMB's
Transportation Information
Return Addressed Stamped Envelope

This packet provides information about the agency, the conditions under which Medicaid is provided and an applicant's rights and responsibilities under the law. The family packet also provides an informational brochure on the state's WIC Program (women, infants and children's supplemental food program in Rhode Island) and the locations of participating WIC facilities.

The DHS-1 and the DHS-2 are the application documents for individuals, (including a blind or disabled child), couples and families which serve as the basis of the Medicaid eligibility determination. These forms and other supplementary forms, as appropriate, constitute an application for Medicaid.

0302.10.05 Assistance in Completing the Application

REV: October 2013

An applicant is informed that a friend, relative, attorney, guardian or legal representative may assist in completing the application forms and that, if needed, a Technician is also available for assistance.

Occasionally a completed application form is received in the district or regional office through the mail without any prior request for assistance. This occurs when credit departments of hospitals provide patients with the forms, and when the Medicaid agency mails an application form to an individual being terminated on SSI.

In such instances, there must be the usual response to the application for Medicaid:

- The date of receipt must be noted on the application form;
- The applicant must be contacted, where appropriate, for information relative to eligibility;
- The application must be acted upon within the applicable time frame; and
- A notice of action must be provided to the applicant.

0302.10.10 Who Must Sign the Application

Repealed October 2013

0302.15 Decision on Eligibility

REV: October 2013

A decision on a Medicaid application for individuals and families eligible under section 1301 and for aged and blind individuals is made within THIRTY (30) DAYS of the receipt of the application by the department. An eligibility decision for disabled individuals is made within NINETY (90) DAYS of the receipt of the application by the department.

An eligibility decision must be made within the above standards except in unusual circumstances when good cause for delay exists.

Good cause exists: 1) when the agency representative cannot reach a decision because the applicant or examining physician delays or fails to take a required action, provided that the agency promptly reviews submitted medical and social data and requests any necessary additional medical documentation from the treating provider within two weeks from the date the completed forms MA-63 (Physician's Report), AP-70 (Information for Determination of Disability) and DHS-25M (Release) are received by the agency, or within two weeks of learning of the existence of a treating provider or of the need to obtain supplementary treating provider information; or 2) when there is an administrative or other emergency beyond the agency's control. The reason for the delay must be documented in the case record. In addition, the applicant must be provided with written notification stating: 1)the reason for delay; and 2)the opportunity for an expedited hearing to contest the delay.

The agency representative makes the decision on eligibility on the basis of information submitted on the application. In every instance, information regarding the applicant's income is verified. Other information is verified as required. Any information on the application which is questionable must be confirmed before eligibility can be certified.

For applications which require a determination of resources (i.e., all SSI related applications and some family-related applications), at least ONE (1) AP-91 FORM is sent to determine the amount of money in, or existence of, a bank account. The form is sent to the bank where the individual has or

had an account. If no account is declared, the AP-91 is sent to the banking institution most likely to have been used by the individual considering the location of home and/or employment.

At redetermination, at least ONE (1) AP-91 form is sent, but to an institution, such as a bank or credit union, not selected at the time of the application.

If a decision cannot be made because of omissions or inconsistencies, the agency representative must contact the applicant by mail, phone or in person for clarification, additional information or verification. If it is necessary for the agency to obtain or confirm any information, the applicant is advised of the necessary steps s/he or the agency must take. If other collateral sources of information must be contacted, the applicant should be informed of why the information is necessary and how it will be used by the agency. The applicant must sign AP-25, Release of Information Authorization, and permit the state to use public records and contact collateral sources for purposes of the eligibility determination.

If an applicant/recipient refuses to present information or verification required to reach a decision on an initial or continuing determination of eligibility and requests the agency not to obtain it, the agency would be unable to determine eligibility and would have no recourse but to deny or discontinue assistance.

In those instances where eligibility is based on the existence of the conditions of blindness or disability, additional medical information verifying these conditions is necessary. Appropriate forms and instructions are provided applicants for submitting this information.

0302.20 Period of Eligibility

REV: October 2013

When an individual is determined eligible for Medicaid, eligibility exists for the entire first month. Therefore, eligibility BEGINS on the first day of the month in which the individual is determined eligible. Medicaid ENDS when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given. Medicaid benefits cease on the last day of the 10-day notice period when eligibility is determined to no longer exist.

However, in cases where the Flexible Test of Income policy is applied, eligibility is established on the day the excess income is absorbed; i.e., the day the medical service was provided.

Eligibility is for the balance of the six (6) month period.

The certification periods for Medicaid beneficiaries are as follows:

- Family, individual, and couple cases, with the exception of flexible test of income cases, are certified for Medicaid up to a maximum of TWELVE (12) MONTHS. Certifications may be for LESSER periods if a significant change occurs or is expected to occur that may affect eligibility. No re-certifications for families and children will be conducted during the period from January 1, 2014 to January 1, 2015.
- Flexible Test of Income cases are certified for Medicaid for the full SIX (6) MONTH (if eligible) or the BALANCE of the SIX (6) month period.

- Individuals eligible for benefits as a Qualified Medicare Beneficiary (QMB), a Special Low Income Medicare Beneficiary (SLMB) or a Qualified Working Disabled Individual (QWDI) are certified for a 12-month period. A Qualifying Individual (QI-1 or QI-2) is certified to the end of the calendar year.

Time limits for certification are established on the InRhodes Statement of Need Panel.

0302.25 Certification of Eligibility

REV: October 2013

Written notice is sent to each applicant who files an application regarding his/her eligibility or ineligibility. When the applicant is found eligible, a NOTICE OF ELIGIBILITY is sent by the agency representative to notify the applicant of eligibility and the length of Medicaid certification.

0302.30 Payment Process

REV: October 2013

Payment for medical care provided within the Medicaid scope of services is made by the department's fiscal agent based on claims submitted by the provider of the medical service and supplies.

The fiscal agent utilizes the Medicaid Management Information System (MMIS) to review the claim and make payment.

Direct reimbursement to recipients is prohibited except in the specific circumstances set forth in Section 0302.30.10 to correct an erroneous denial which is reversed on appeal.

0302.30.05 Medicaid as Payor of Last Resort

REV: October 2013

Medical insurance is not a bar to eligibility. However, all benefits for which the recipient is eligible must be paid before the Medicaid Program assumes responsibility for payment.

State law makes it illegal for insurance companies to exclude Medicaid recipients from benefits, reinforcing the requirement of third-party liability (TPL) and that Medicaid is the last payer.

0302.30.10 Direct Reimbursement to Recipients

REV: October 2013

Some individuals, while appealing a determination of Medicaid ineligibility, incur and pay for covered services. To correct the inequitable situation which results from an erroneous determination made by the Medicaid agency, direct reimbursement is available to recipients in certain circumstances. Direct reimbursement is available to such individuals if, and only if, all of the following requirements are met:

1. A written request to appeal a denial or discontinuance of Medicaid coverage is received by the State within the time frame specified in Section 0110.20.

2. The original decision to deny or discontinue Medicaid coverage is determined to be incorrect and, as such, is reversed on appeal by the Appeals Officer (hearing decision) or by the Regional Manager or Chief Supervisor/Supervisor (adjustment conference decision).

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

3. The recipient submits the following:

- A completed Application for Reimbursement form (MA 1R);
 - A copy of the medical provider's bill or a written statement from the provider which includes the date and type of service;
 - Proof of the date and amount of payment made to the provider by the recipient or a person legally responsible for the recipient. A cash receipt, a copy of a canceled check or bank debit statement, a copy of a paid medical bill, or a written statement from the medical provider may be used as proof of payment provided the document includes the date and amount of the payment and indicates that payment was made to the medical provider by the recipient or a person legally responsible for the recipient.
4. Payment for the medical service was made during the period between a denial of Medicaid eligibility and a successful appeal of that denial. That is, payment was made on or after the date of the written notice of denial (or the effective date of Medicaid termination, if later) and before the date of the written decision issued by the EOHHS Appeal Office, or decision by the Regional Manager/Chief Casework Supervisor after adjustment conference, reversing such denial is implemented (or the date Medicaid eligibility is approved, if earlier).

Procedure and Notification

Notices of Medicaid ineligibility provide applicants and recipients with information about their rights to appeal the agency's decision. These notices also contains specific information about the availability of direct reimbursement if a written appeal is filed and the State's initial decision is overturned as incorrect. The rules governing appeals and hearings are located in DHS and EOHHS rule section #0110.

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

The individual must complete and sign the Application for Reimbursement form and include: a) a copy of the provider's bill showing date and type of service; and b) proof that payment was made by the recipient or a person legally responsible for the recipient between the date of the erroneous denial and the date of the successful appeal decision. The completed form and required documentation is returned to the appropriate department representative.

If either the bill or proof of payment is not included with the Application form, the Medicaid agency representative offers to assist the recipient in obtaining the required documentation, and sends a

reminder notice requesting return of the required information within thirty (30) days from the date of receipt of the MA-1R. If all documents are not received within thirty (30) days, or if the documentation provided indicates that medical service or payment was not made between the date of Medicaid denial (or termination) and the date of Medicaid acceptance (or reinstatement), the agency representative denies the request for reimbursement.

Otherwise, the agency representative forwards a referral form (DHS-48R), attaching the recipient's written request for reimbursement and all supporting documentation to the Medicaid agency for a decision on payment. The Medicaid agency is responsible for providing the individual with written notification (DHS 40A or DHS 167A) of the agency's decision and rights to appeal.

For Further Information or to Obtain Assistance

March 2014

01. Applications for affordable coverage are available online on the following websites:
 - www.eohhs.ri.gov
 - www.dhs.ri.gov
 - 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 1-855-609-3304 and TTY 1-888-657-3173.
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).

Severability

October 2013

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.