

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services



Access to Medicaid Coverage under the Affordable Care Act

Section 1318:

Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals

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Rhode Island Executive Office of Health and Human Services
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Rules and Regulations Section 1318:
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Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1318 of the Medicaid Code of Administrative Rules entitled, “Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals”** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-152); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR 435 §§ 1102 and 1103.

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.

These regulations shall supersede all previous requirements related to Medicaid presumptive eligibility determinations made by Rhode Island hospitals as contained in MCAR section 1305.15, "Access to Medicaid Coverage Under the Affordable Care Act: Eligibility for Medicaid Affordable Care Coverage Groups" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State on December 11, 2013.

1318 Presumptive Eligibility for Medicaid as Determined by Rhode Island Hospitals

1318.01 Overview and Statutory Authority

The goal of the federal Affordable Care Act (ACA) of 2010 is to improve access to high quality health insurance coverage for people of all ages and income levels. In keeping with this purpose, the ACA established a presumptive eligibility program for certain individuals and families in the newly reconfigured Medicaid Affordable Care Coverage (MACC) groups. The MACC groups in Rhode Island are described in the Rhode Island Medicaid Code of Administrative Rules (MCAR), Section 1301.

Federal regulations governing the program at 42 Code of Federal Regulations (CFR) §435.1110 authorize the states to provide Medicaid for a limited period of time to individuals who are determined by a “qualified hospital”, on the basis of preliminary information, to be presumptively eligible for Medicaid. This initial determination is made by the hospital on the basis of the characteristics for MACC group eligibility. The states have the discretion under these provisions to tailor presumptive eligibility requirements program within certain parameters to meet their own unique needs.

1318.02 Scope and Purpose of Hospital Presumptive Eligibility Program for Medicaid

The State of Rhode Island had determined that presumptive eligibility will be available to individuals in the MACC groups who qualify for Medicaid-funded affordable coverage. For all other individuals with MACC-like characteristics, presumptive eligibility must be determined by a qualified hospital, licensed in Rhode Island, and is only available in certain circumstances contingent upon preliminary information supplied by the individual. Further, presumptive eligibility is only available on a temporary basis – until the last day of the month following the initial determination of presumptive eligibility or the date full eligibility is determined, whichever comes first.

(01) Exclusions: Individuals in the MACC groups who are eligible for affordable coverage funded through the Children’s Health Insurance Program (CHIP) under Title XXI of the U.S. Social Security Act are excluded from presumptive eligibility. CHIP-funded beneficiaries excluded from HPE are as follows:

- All lawfully present non-citizen children while subject to the federal five (5) year ban;
- Children up to age 19 with income from 133% to 261% of the FPL;
- All non-qualified non-citizen pregnant women with income up to 253% of the FPL; and
- Pregnant women with income from 185% to 253% of the FPL.

01. Implementation – Effective January 27, 2014, the State will be making presumptive eligibility available to individuals who have been determined by a qualified hospital to meet the characteristics of one of the MACC groups identified in MCAR section 1301 (and as below)

eligible for Medicaid-funded affordable coverage under Title XIX, with the exception of the exclusions noted above.

02. **Governing Provisions** – The purpose of these rules is to set forth the provisions governing hospital presumptive eligibility determinations including, but are not limited to the:

- Qualifications of applicants for Medicaid presumptive eligibility;
- Criteria that a qualified hospital must use when making a determination of presumptive eligibility;
- Application timelines and procedures for individuals who qualify for Medicaid coverage during the presumptive eligibility period.

1318.03 Definitions

“Children’s Health Insurance Program (CHIP)” means the program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.

“Executive Office of Health and Human Services (EOHHS)” means the designated “single state agency”, authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*), to be legally responsible for the programmatic oversight, fiscal management, and administration of the Medicaid program.

“Hospital Presumptive Eligibility (HPE)” means Medicaid eligibility granted on a temporary basis to a person who meets certain criteria during a defined period.

“Medicaid Affordable Care Coverage (MACC) Groups” 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.

“Medicaid Code of Administrative Rules (MCAR)” means the compilation of rules governing the Rhode Island Medicaid Program, promulgated in accordance with the State’s Administrative Procedures Act (RIGL §42-35).

“Qualified Hospital” means any licensed Rhode Island hospital participating in the Medicaid program that executes a Notice of Intent to Participate in the HPE Program and a Memorandum of Understanding with EOHHS to conduct presumptive eligibility determinations, participates in training and certification sponsored by EOHHS, and remains in good standing with EOHHS protocols.

“Self-Attestation” means the act of a person affirming through an electronic or written signature that the statements the person made when applying for Medicaid eligibility are truthful and correct.

1375.04 Populations Eligible for HPE

01. Qualified hospitals participating in the HPE Program may complete presumptive eligibility assessments for individuals who have the characteristics of members of the MACC groups funded through Title XIX. HPE excludes individuals eligible for coverage funded through CHIP and any individuals eligible for Medicaid on the basis of age, blindness or disability and/or in need of Medicaid-funded long-term services and supports.
02. Qualified hospitals are authorized to make presumptive eligibility determinations for individuals who demonstrate potential Medicaid eligibility in one of the following MACC groups, but only as specified:
 - a) 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 with income up to 133% of the FPL under the age of 18, or 19 if enrolled in school full-time.
 - b) Pregnant women with income up to 185% who are United States citizens or qualified non-citizens. Members of this coverage group can be of any age. Pregnant women are limited to one (1) HPE determination per pregnancy.
 - c) Children and Young Adults up to the age of 19 with income up to 133% of the FPL (CHIP exclusions apply).
 - d) 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.

1318.05 Scope of Coverage

01. **Eligibility Period.** The hospital presumptive eligibility period begins, and includes, the date the hospital makes the HPE determination. The hospital presumptive eligibility period ends on the date that the Medicaid agency renders a determination for full Medicaid eligibility; or the last day of the month following the month in which the hospital made the HPE determination, whichever comes first.
02. **Covered Services.** Individuals determined eligible for HPE, receive the same scope of State Plan and Section 1115 waiver services as members of a MACC group, except as follows:
 - All HPE beneficiaries -- No transportation services.
 - Pregnant women -- Maternity services are limited to prenatal ambulatory care only. (Birthing expenses are not covered.)

03. **Service Delivery.** Individuals determined to be presumptively eligible for Medicaid are enrolled in a fee-for-service plan. When full Medicaid eligibility is determined, participants will be enrolled at EOHHS' discretion in a managed care organization (MCO), as indicated in MCAR Section 1311.

1318.06 Requirements for Hospitals

A hospital must meet certain requirements to be deemed qualified to participate in the HPE.

01. **Participation.** A qualified hospital must be licensed in RI and a participating Medicaid provider under the Rhode Island Medicaid State Plan or Section 1115 waiver. The hospital must notify EOHHS of its election to make presumptive eligibility determinations, and agree to HPE determinations in compliance with State policies/procedures and these rules.

02. **Application Process:** The qualified hospital must:

- (a) Assist individuals in completing and submitting the full application for health insurance affordability programs in Rhode Island. This assistance includes assuring that the individual understands any documentation requirements.
 - (b) NOT require individuals assessed for HPE to verify information related to any HPE eligibility criteria/characteristic, including pregnancy.
 - (c) Accept self-attestation of income, citizenship, and residency, as applicable, when determining eligibility.
 - (d) Provide individuals with written notice after the HPE determination is made that includes, but is not limited to:
 - HPE determination (i.e., approved or denied);
 - If approved, the beginning and ending dates;
 - If denied, the reason(s) for the denial, options for submitting a regular Medicaid application and information on how to make application.
 - e) The qualified hospital must utilize EOHHS-approved materials and methods in determining HPE and completing full Medicaid applications, including the EOHHS and HSRI websites and the State's single streamlined application.
03. **Confidentiality.** The qualified hospital must comply with all applicable State and federal laws and regulations regarding patient privacy and the confidentiality of health care communications and information.
04. **Records Retention.** In accordance with the provisions of the state agency's record retention policy, the qualified hospital shall maintain organized records of all HPE applications for ten (10) years from the date the last Medicaid billing was submitted to EOHHS.

05. **Medicaid Agency Notification.** The qualified hospital shall notify the state agency of HPE approvals, and the applicable date ranges, within five (5) business days.

06. **Hospital Staff.** The qualified hospital must only use employees of the hospital to assist with HPE applications. The hospital is prohibited from subcontracting HPE work to a non-hospital based company or independent contractor. In addition:

- (a) Each qualified hospital shall have a minimum of one (1) staff member trained and certified to perform HPE duties on each shift.
- (b) The hospital must affirm that all HPE personnel meet the minimum qualifications specified herein and comply with EOHHS policies and procedures for participation in the Medicaid hospital presumptive eligibility program and participate in all trainings, knowledge-based tests, and keep up-to-date on notifications with regard to HPE. The hospital must assign one accountable individual to be the liaison with the State Medicaid Agency and its designees.
- (c) The qualified hospital HPE staff must assist Medicaid applicants with the completion and submission of a Medicaid application. Additionally, qualified hospital staff must provide the information specified in this subsection pertaining to the HPE decision, eligibility period, and requirement to complete a full application.
- (d) HPE staff must complete the requisite EOHHS training and maintain knowledge of any program changes. HPE staff training must include: in-person training; computer-based training; and proficiency testing and certification. Training and testing shall be completed at specific intervals as directed by EOHHS, but no less than annually.
 - Assignment of Qualified Hospital Staff Online Application Credentials. Prior to assignment of online HPE administrator credentials, qualified hospital staff must complete EOHHS-approved training and provide documentation of completion of training in the format required. Proof of training also must be made available upon request by applicants.
 - Proficiency standards. Hospital HPE staff must achieve the minimum certification testing score set forth in contractual standards established with EOHHS.

1318.07 Reporting

The qualified hospital must submit monthly reports in a standardized format as defined by EOHHS. These reports must be submitted electronically by the fifth business day of the month following HPE determinations. The reports must reflect accurate measurement of the performance requirements described in section 1318.08 below. In addition, the qualified hospital must prepare and submit any ad-hoc reports to EOHHS upon request.

1318.08 Performance Requirements

The EOHHS requires that a qualified hospital meet certain performance standard to continue participation in the HPE. First, the qualified hospital must submit full Medicaid applications for ninety-five percent (95%) of the individuals granted HPE within five (5) calendar days from the date of the initial determination of presumptive eligibility. Second the percentage of these Medicaid applications that must be deemed fully complete by the EOHHS -- that is, contain no errors or otherwise require the State's intervention in processing -- is set forth in contractual standards between

the hospital and the EOHHS. Last, the number of individuals qualifying for HPE who must be determined to be eligible for full Medicaid, as determined by the EOHHS, is also set forth in the Notice of Intent to Participate in the HPE Program and a Memorandum of Understanding with EOHHS for the qualified hospital established by EOHHS. In the event a qualified hospital does not meet acceptable performance standards, participation in the HPE may be suspended or terminated at the discretion of the EOHHS.

1318.09 Office of Program Integrity Agency Authority

The EOHHS may undertake an array of actions to assess whether qualified hospitals are meeting the performance standards for the program. The EOHHS Office of Program Integrity (OPI) has been assigned responsibility for performing routine audits and intensive reviews of the HPE program, as appropriate. The OPI is also responsible for overseeing the development and submission of any hospital Corrective Action Plans deemed warranted. The OPI initial audits will commence within the first six (6) months of the program's start-up date and then be performed annually thereafter or as needed.

1318.10 Corrective Action

In the event a qualified hospital does not achieve proficiency on the performance requirements outlined in subsection 1318.08, the EOHHS may require the development of Corrective Action Plan (CAP) indicating interventions the hospital proposed to take to achieve compliance with these and/or other contractual standards. The OPI is responsible for reviewing and monitoring compliance with the CAP. HPE determinations may be suspended while the CAP is being prepared or implemented, as appropriate.

EOHHS reserves the right to request modifications to the CAP if the CAP is deemed ineffective to achieve compliance;

- The qualified hospital must submit weekly CAP reports to EOHHS measuring the outcome of the corrective actions the hospital has instituted;
- HPE suspensions remain in full force and effect until such time as the hospital demonstrates to EOHHS that it has instituted corrective measures to bring the hospital into full compliance with State and federal requirements.

1318.11 For Further Information or to Obtain Assistance

For further information or to obtain assistance, please contact:

Deborah Florio, Administrator
Executive Office of Health and Human Services
Deb.Florio@ohhs.ri.gov

1318.12 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.