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Chief, Family Health Systems

Executive Office of Health and Human Services

600 New London Ave.

Cranston, RI 02902

RE: Proposed Rules, Sections 1301, 1303, 1305, 1308, 1309, 1310, 1311, 1312, 1315.

Dear Ms. Shelov:

Below are comments on a number of the proposed rules implementing changes to the Medicaid program required by the Patient Protection and Affordable Care Act. I appreciate the effort it took to revise current regulations and write so many new sections. I hope these comments are helpful and would be happy to discuss further.

Section 1301. New Rule on Medicaid Coverage Groups

1301.02 Definition

Non-citizen: There are lawfully present non-citizens who are not "qualified" as that term is used in federal rules. Parents and adults must be "qualified" (and some have a waiting period), children are eligible if they are "qualified" or lawfully present (a broader set of immigration categories). The rule should be changed to reflect this. And see comment for 1301.03 (.01) below.

Non-MAGI Coverage Group: The definition is not correct. There are aged, blind and disabled individuals who are eligible for Medicaid and do not need LTSS. MAGI does not apply to these individuals. The definition should be amended to reflect this.

RIte Care – should clarify the age of "children" and "young adults". In section 1301.03 (03), the category of "Children and Young Adults" includes infants, under one, children from age 1 to age 19. Does children encompass young adults? Or is there a separate group of "young adults" who are not "children"?

1301.03. Types of Medicaid Affordable Care Coverage Groups

.01: Subsections (02) and (03) include a reference to whether a non-citizen is eligible for coverage. For pregnant women it includes all non-citizens ("qualified" and undocumented), for children it includes "qualified". But there is no similar reference to eligibility of "qualified" non-citizens for parents and adults 19-64. There should be. Parents and adults are eligible if they are "qualified" – although some may have a waiting period. Children are eligible if they are "qualified" (per the technical federal definition) or if they are lawfully present. See comment on definition of "non-citizen" above.

.03. The second sentence is incorrect. When the income calculation for a household is made, the MAGI income is reduced by an amount equal to 5% of the FPL for the household size; the income is not adjusted upward – it is adjusted downward. This makes the applicable income limit five percentage points higher. The meaning of the next two sentences (In addition…) is simply unclear.

.04. This definition does not conform to the federal definition: An eligible adult could have "dependent children" (e.g., a non-custodial parent) so strike this. Medicaid eligibility through some other coverage group should be replaced with: eligible for or enrolled in a Medicaid State Plan mandatory coverage group. Add: not entitled to or receiving Medicare part A or B. It would be helpful to clarify here that an individual who has been found eligible for Social Security Disability benefits and is in the 24 month "waiting period" for Medicare, is eligible under this category.

1301.04 Medicaid Coverage Groups Excepted from MAGI

Should add : Women eligible under the Breast and Cervical Cancer Treatment Act; youth aging out of foster care ("Chafee youth"); Katie Beckett children and youth; infants born to woman covered by Medicaid.

In third box: replace "adults" with "Adults age 65 or older"; in the last box replace "Elders" with "adults age 65 or older".

1301.05 MACC and Non-MAGI Coverage Groups: Distinctions and Overlaps

01.(02). Regarding Transitional Medical Assistance: During the first 6 months of TMA, income is not considered. During the second 6 months of TMA, when income must be below 185% FPL, the MAGI income methodology applies. While there is a question about whether TMA applies to families when the conversion from current methodology to MAGI is applied, there is not a question about whether the MAGI methodology is applied when the family with MAGI income below 110%FPL has income that exceeds this limit due to increased earnings. Does the statement "It is unclear whether TMA families will be subject to the MAGI at this writing" refer to the conversion situation only?

.04 Young Adults Former Foster Care: The rule confuses the requirement that the youth is required to have "aged out" of foster care in RI to be eligible with the requirement that the youth must be a RI

resident. (01) provides that the young adult is eligible if they aged out of DCYF foster care – this could be made clearer by including that the "young adult was in DCYF foster care in Rhode Island. (04) Residency should be amended to state: The young adult must be living in Rhode Island.

We propose that EOHHS exercise the option to provide "Chafee coverage" to young adults who aged out of foster care in another state and are now Rhode Island residents. These young adults would benefit from the income protection provided by this category of coverage.

SECTION 1303: Application Process

1303.01. Adults 19 – 64:

Should conform to federal definition and be consistent with definition in 1301.03. Should read: "Adults 19-64 with income up to 133% FPL who are not pregnant, entitled to or receiving Medicare Part A or B, or otherwise eligible for or enrolled in a Medicaid State plan mandatory coverage group". It would be helpful to clarify here that an individual who has been found eligible for Social Security Disability benefits and is in the 24 month "waiting period" for Medicare, is eligible under this category.

1303.02 Definitions

Application Entity: Is the application entity intended to include the 3 state agencies? If so, then it's incorrect to say that the application entity is acting on behalf of the state agency. The definition should clarify that "any organization designated for such purpose" means an organization that includes staff who have been certified as Navigators by the state or its designee.

1303.04. Completing and Submitting the Application

01. (01). This section is confusing and inaccurate. Change to read: "The applicant must provide personally identifiable information to prove their identity to establish an account. Verification of identity is an automated process conducted through the federal data hub. If the automated process is unsuccessful, the applicant can provide documents proving identity, including a driver's license. For a list of all acceptable documents see Section 1308.08. Documents can be uploaded on-line, faxed or presented to the Contact Center. Copies can be mailed to the Contact center."

What is the timeframe for providing the documents before the "application is closed". How is the applicant notified of the timeframe? If the person mails in the documents, how are they notified that identity has been established and that they can resume the application process? These procedures should be specified in the rule.

01. (03). Temporary eligibility period: Amend to provide that temporary eligibility is (not may be) granted for 90 days (not "up to" 90 days) to provide the applicant with time to provide the required documentation.

03. Application Materials. This section really is describing "information" that is necessary to provide during the application process. Some of that information is contained in "materials" – e.g., federal tax return, W-2 forms, 1099 forms, but these are not documents that must be provided. Suggest changing to "information required". Need to provide that a RI address is not a required element – and specify that individuals who are homeless are eligible.

.04 Application Completeness. Replace "must provide this information as soon as feasible" with "immediately". Specify how the applicant is notified of the need for additional information (when not applying on-line) by phone, letter?

1303.05 Attestation of Application Information

01. Attestation. Fails to specify how a signature is obtained when the person is applying on-line.

1303.07. Notice of Determination of Eligibility

This section is confusing. It may help to have separate sections describing what happens when applying on-line and when applying using the paper application. Also suggest providing an explanation of the integration of the decision regarding Medicaid and HSRI, as follows:

"Once an application is complete and the required verifications are provided, a determination of eligibility for Medicaid or for coverage through HealthSource RI (including federal and state assistance for which the household member is eligible) is made for each member of the household. Household members determined eligible for Medicaid can immediately enroll in a Medicaid plan. (For information about affordable coverage through HealthSource RI see…..)

A notice is sent within 48 hours after the eligibility determination informing the applicant which household members have been found eligible for Medicaid (and the plan in which they have enrolled), which members have been determined ineligible for Medicaid and the reasons therefor. (The notice also explains which members have been found eligible for coverage through HealthSource RI (and the amount of state and federal assistance for which they qualify) and which members are not eligible.) The notice informs the applicant of the right to appeal and how to request a hearing on the eligibility determinations."

1303.08 Agency Roles and Responsibilities

02. (01). Applicant Rights: add to anti-discrimination sentence: gender identity, sexual orientation.

Section 1305. Eligibility Requirements

1305.07 Overview of Non-Financial Requirements

The rule refers to MCAR section 1304 for information about the federal data hub. However, there is no such current or proposed section.

1305.11 State Residency

02. Individuals under age 21. The proposed rule states: If the applicant is not living in an institution, the state of residence is the state where the parent/guardian applying for the applicant lives. This does not follow the federal rule and should be amended to do so.

The federal regulation (42 CFR 435.403) provides that residence for an individual under age 21 is the state where the individual resides including without a fixed address or the state of residence of the parent/caretaker with whom the individual resides.

1305.17 Cooperation Requirements

02. Referral to Office of Child Support Services (OCSS) – EOHHS cannot require applicants to "cooperate with child support" as part of the application process and therefore cannot require cooperation as a condition of initial eligibility. The rule should be revised to clarify that cooperation is a post-eligibility requirement.

The rule concerning cooperation with child support (post-eligibility) must also explain rights regarding "good cause" not to cooperate where domestic violence is involved. The rules should provide for referral to the Family Violence Option project to assist the parent in establishing good cause not to cooperate. The current proposed rule regarding establishing good cause for non-cooperation is not adequate or appropriate for establishing good cause for non-cooperation with child support where domestic violence is implicated.

Section 1308: Verification of MACC Group Eligibility Factors

1308.03 Definitions

Self attestation: This is not an accurate definition. There are certain eligibility factors for which "self attestation" is sufficient. There is no requirement that self-attestation is accepted only if no data match is found or the information is outdated or incorrect. According to the MAGI-Based Eligibility Plan submitted by EOHHS to CMS, these factors are residency, household composition, caretaker relative and pregnancy.

1308.04 – 1308.10

These sections should be rewritten to reflect the verification procedures outlined in the MAGI-based Eligibility Verification Plan submitted to CMS. Each eligibility factor should be listed along with whether self-attestation is sufficient; whether there is self-attestation with post-eligibility verification or whether verification is required prior to eligibility determination. The eligibility factors are: income, residency,

age, social security number (if the individual has one), citizenship, immigration status, household composition, pregnancy, caretaker relative, medicare, application for other benefits. Note that for residence it is important to spell out that a person need not have a permanent address to be a RI resident. A homeless individual is eligible. The data sources used for each eligibility factor should be listed (not in the vague way that the sources are listed in 1308.05). How the data sources are used for each eligibility factor is also included in the Verification plan. The "reasonable compatibility standard" is limited to discrepancies in income only according to the Verification plan If the "reasonable compatibility standard" is used in other circumstances as indicated in the regulations – examples should be provided and the Verification plan needs to be amended. (Note that Section 1305 provides good examples of explaining some of the non-financial eligibility factors, whether self-attestation is accepted, etc.)

While these sections need to be rewritten, some specific questions and errors are:

1308.04: (01.).01. Federal Data Hub: As mentioned above, the data sources should be linked to the specific eligibility criteria. The sentence "various categories of data from these sources are combined on income, employment… doesn't make sense. Why is "health" included in this list? Since residency (in Rhode Island) is established by self-attestation, why is there a reference to vital records and residency. And vital records are a state data source, not a federal one.

02: Reasonable compatibility only applies to income.

03: There is an incomplete sentence in this paragraph.

<u>1308.05. Eligibility Factors and Verification Medicaid</u>

Title is not grammatically correct.

Identify: Identify proofing has been a problem. This section should explain how identity is established if the federal data hub and the third party organization does not establish identity.

<u>1308.06. Medicaid Reasonable Compatibility Standard</u>

.01. Is correct in that if the attestation of income and the data are both below the applicable Medicaid income standard, the individual is eligible. The paragraph contains redundancies and should be simplified.

.02. is correct but should include the statement that the individual's eligibility for APTC/CSR is reviewed.

There is also "reasonable compatibility" if the reported income and the data are AT the applicable Medicaid income standard.

.03 and .04 do not comport with what was reported in the Verification Plan which provides:

If the individual attests to income below the applicable Medicaid standard and the data source indicates income above the standard, if the difference is 10% or less, the reasonable compatibility standard is met and the individual is eligible for Medicaid. If the discrepancy is more than 10%, a reasonable explanation is requested and/or paper documentation.

(We agree with the proposed rule (1308.07) which provides that if the applicant identifies one of the listed reasons as the explanation for the discrepancy between reported income and the data source, then a "reasonable explanation" has been provide and no additional documentation is required.)

If the individual attests to income above the applicable Medicaid standard and the data sources indicate income below, the individual is determined ineligible for Medicaid and is reviewed for eligibility for APTC/CSR.

1308.07 Reasonable Explanation

As noted above, the "reasonable explanation" comes into play when there is a discrepancy between reported income and income from data sources. The text indicates that other eligibility factors may be subject to "reasonable explanation" but the box indicates the list is for discrepancies in income. Assuming this is/should be about income, "homeless" doesn't seem to fit, death in family (death of individual with income?).

1308.10. Satisfactory Documentation

Identity: there are other documents that should be acceptable to prove identity: voter registration card, US military card, tribal card.

Section 1309: RIte Care

1309.04 Definitions

Medicaid Affordable Care Coverage Group: Add Transitional Medical Assistance.

Non-MAGI Coverage Group: Delete "and in need of long-term services and supports" – persons who are aged, blind or disabled who are eligible for Medicaid based on that "status", even if they do not need LTSS, are not in the MAGI group.

1309.06 Excluded Medicaid Coverage Groups

(03) Extended family planning group: should specify how long EFP coverage lasts.

1309.07 Retroactive Coverage

Should specify the "certain circumstances" under which retroactive coverage is available for foster and adoption subsidy children in Non-MAGI coverage groups.

1309.09 Overview of Rite Care Services

04. EPSDT. Requires clarification re: EPSDT for "young adults up to age 21" and for MACC group up to age 19. Clarify that when a "child" loses Rite Care eligibility at age 19 and transitions to the new Medicaid expansion group – as a single childless adult, he/she is eligible for EPSDT until he/she turns 21. Also, note that this last sentence indicates that youth aging out of foster care are eligible for EPSDT until they turn 26 – but EPSDT ends when the young adult turns 21.

1309.10 RIte Care In-Plan Capitated Benefits

"Prudent lay person" should be explained.

Citations in "non-emergency transportation", interpreter services, and tracking follow-up and outreach are wrong.

(02) Non-emergency transportation policy. It is not logical to say that "if the member's condition… does not permit the use of bus transportation" the type of non-emergency transportation includes bus passes, RHody Ten Ride passes, etc. Rite Care members are entitled to transportation to medically necessary appointments. This includes receiving the Rhody Ten Ride pass so they can take the bus. If the person can't take the bus, then alternative transportation (paratransit vans and taxi services) must be provided. Is the policy still that Rite Care members can receive a Rhody Ten Ride pass upon request and that if additional assistance is necessary they can request it? If so, the rule should so state.

1309.11 In-plan Fee-For-Service Benefits

Family Planning Services: Strike the language "due to issues or concerns related to confidentiality" in the last sentence. Members are free to go to an out-of-plan provider for family planning services . They do not need to give a reason for choosing this option.

1309.13 EPSDT Out-of-plan Services

in the first sentence change "excluding" to "including". Former foster care young adults are eligible for EPSDT until their 21st birthday.

1309.21 Exemptions from managed care – rite care only

Clarification needed re: "… there is a special exemption for foster children under age 26. Children in this coverage group may be exempted from health plan enrollment upon request of DCYF". Is this intended to apply just to children in foster care – or also the young adults aging out of foster care? It should not

apply to youth aging out of foster care. And, what are the circumstances under which DCYF can request that a child in foster care be exempt from managed care?

Section 1310: Rhody Health Program

1310.04 Definitions

Non-MAGI Coverage Group: See comment under RIte Care definition above.

1310.07 RHP In-Plan Capitated Benefits

Non-emergency transportation policy. See comment under RIte Care non-emergency transportation policy above.

1310.09 Out-of-plan benefits

Family Planning Services. See comment under RIte Care above.

Section 1311: Enrollment Process

1311.21 Disenrollment Effective Dates

The rule should provide that when an individual who is notified of termination from Medicaid files a timely request for hearing so that benefits continue pending the hearing decision, the individual is not disenrolled from the health plan until the hearing decision is reached. An individual who is pursuing his/her right to retain Medicaid coverage needs to continue to be enrolled in the delivery system upon which he/she relies. Providing fee-for-service coverage during the appeal process is not sufficient to ensure access to necessary care.

Section 1312. RIte Share Premium Assistance

1312.03. Definitions

Rite Share Buy-In. Change to: "Means the monthly amount the parent/caretaker of a Medicaid-eligible child can pay toward RIte Share-approved ESI to allow the parent to enroll in ESI with his/her children. The RIte Share buy-in applies to households with income above 150% FPL." If the parent doesn't pay the "buy in" then the children would be enrolled in RIte Care.

Wrap around services or coverage. Co-payments to providers should be covered to ensure that children in Rite Share have the same benefits as children in Rite Care. If the provider does not accept Medicaid, then the co-payment is not covered and this needs to be explained to the parent.

1312.04. Rite Share Populations

(01) It is not clear why mandatory participation in Rite Share is set at 150% FPL and not 138% FPL. What parents or (single) adults would be eligible for Medicaid with income above 138% FPL and below 150% FPL?

(02) income above 150% FPL. For families – since the parent will not be eligible for Medicaid, but the children will, if the parent does not agree to enroll in ESI, the children must continue to be eligible for Medicaid. It is expected that the parent will want to take advantage of being able to enroll in ESI (with or without a "buy in") since that will generally be a more cost-effective way to obtain coverage than enrolling through HSRI.

Note: Section 1312.05.03 correctly provides that children are not terminated from Rite Care if their non-MA eligible parent fails to enroll in ESI. (Failure to meet the mandatory enrollment requirement results in termination of the Medicaid eligibility of the policy holder and other Medicaid members nineteen and older…). This should be reflected in other sections of the regulations as suggested above.

1312.07 Rite Share Premium Assistance

.02. It is not logical to say that co-pays are not covered but RIte Share enrollees are not required to pay co-payments to Medicaid certified providers.

1312.08 RIte Share Buy-in Requirement

Parents and caretaker relatives with income above 150% FPL are not eligible for Medicaid. The "Rite Share Buy-in" allows a parent who is not eligible for Medicaid to enroll in ESI with his/her Medicaid eligible children. It is not logical to say that the notice about the Rite Share buy-in is provided to the "Medicaid member" since this will be a child. The notice is provided to the non-Medicaid eligible parent/caretaker relative. The notice should explain the benefit of the "buy in" and the consequence of not enrolling – which is that the child(ren) will remain in RIte Care. As provided in 1312.20 disenrollment from Medicaid can only be applied to individuals over the age of 19.

1312.14. Non-custodial parents with TPL.

.01. The rule should include examples of "good cause" for not requiring a child to transition to RIte Share when a non-custodial parent has ESI. Good cause should include: the non-custodial parent's ESI is an out-of-state policy; the coverage is not comprehensive; the child has verified medical reasons to treat with a particular doctor and that doctor is not in the NCP's ESI network. EOHHS/DHS should review the cases where "good cause" has been found and include the reasons in a list of examples of "good cause".

Section 1315: Rhode Island Affordable Health Care Coverage Assistance Program

The additional financial assistance provided by the Affordable Health Care Coverage Assistance (AHCCA) program will be critical to supporting low-income parents' enrollment into coverage through HealthSource RI. Of the parents who are losing Rite Care coverage in January 2014, half have never been considered able to afford monthly premiums and the other half have paid $61/month to enroll themselves and their children. None of these parents have incurred out-of-pocket expenses for care. The AHCCA will also provide help to new parents seeking health insurance for themselves and their children for the first time after January 1, 2014.

Because the state assistance may make the difference between a parent deciding to enroll or to forego coverage because it is not affordable, it is important that the parent know the amount of state assistance to which he/she is entitled when he/she is completing the application process. The "standard amount" for which the parent is eligible should be made known to the parent during the application process. While the payment may not be made until after the parent enrolls, the parent must know what the actual cost of enrolling will be.

The regulation should include the standard amounts.

Because these are families living on the economic margins, the AHCCA payment should be made available as quickly as possible. Sixty days is too long.

Access to the AHCCA should be automated as quickly as possible, so the applicant can immediately know the amount to which she/he is entitled and can access the payment at the same time she/he enrolls in a qualified health plan.

Thank you for your consideration of these comments. I look forward to your response.

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