

STATE Rhode Island**OFFICIAL**DUPLICATE
19-3-4

- | | | |
|-----|---|--|
| 1. | In-patient hospital services other than those provided in an institution for mental disease or tuberculosis | All services for one recipient within a bill |
| 2a. | Out-patient hospital services | All services for one recipient within a bill |
| 2b. | Rural health clinic services and other ambulatory services furnished by a rural health clinic | All services for one recipient within a bill |
| 3. | Other laboratory and x-ray services | All services for one recipient within a bill |
| 4a. | Skilled nursing facility services (other than services in an institution for tuberculosis or mental disease) for individuals 21 years of age or older | A bill of services |
| 4b. | Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found | All services for one recipient within a bill |
| 4c. | Family planning services and supplies for individuals of child-bearing age | All services for one recipient within a bill |
| 5. | Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere | All services for one recipient within a bill |
| 6a. | Podiatrists' services | All services for one recipient within a bill |
| 6b. | Optometrists' services | All services for one recipient within a bill |
| 6c. | Chiropractors' services | Not provided |
| 6d. | Other practitioners' services | All services for one recipient within a bill |

STATE Rhode IslandOFFICIAL ~~DUPLICATE~~

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| 7a. | Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area | All services for one recipient within a bill |
| 7b. | Home health aide services provided by a home health agency | All services for one recipient within a bill |
| 7c. | Medical supplies, equipment and appliances suitable for use in the home | All services for one recipient within a bill |
| 7d. | Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility | All services for one recipient within a bill |
| 8. | Private duty nursing services | Not provided |
| 9. | Clinic services | Not provided |
| 10. | Dental services | All services for one recipient within a bill |
| 11a. | Physical therapy | Not provided |
| 11b. | Occupational therapy | Not provided |
| 11c. | Services for individuals with speech, hearing and language disorders (provided by or under the supervision of a speech pathologist or audiologist) | Not provided |
| 12. | Prescribed drugs, dentures and prosthetic devices; and eye-glasses prescribed by a physician skilled in disease of the eye or by an optometrist | All services for one recipient within a bill |

R.I. Incorp. 1/3/80 Effective 10-1-79

STATE Rhode Island**OFFICIAL**

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| 12a. Prescribed drugs | All services for one recipient within a bill |
| 12b. Dentures | All services for one recipient within a bill |
| 12c. Prosthetic devices | All services for one recipient within a bill |
| 12d. Eyeglasses | All services for one recipient within a bill |
| 13a. Diagnostic services | Not provided |
| 13b. Screening services | Not provided |
| 13c. Preventive services | Not provided |
| 13d. Rehabilitative services | All services for one recipient within a bill |
| 14. Services for individuals age 65 or older in institutions for mental disease | |
| a. in-patient hospital services | All services for one recipient within a bill |
| b. skilled nursing facility services | All services for one recipient within a bill |
| c. intermediate care facility services | All services for one recipient within a bill |
| 15a. Intermediate care facility | A bill for services |
| 15b. Including such services in a public institution for the mentally retarded or persons with related conditions | A bill for services |
| 16. In-patient psychiatric facility services for individuals under 22 | All services for one recipient within a bill |
| 17. Nurse Mid Wife services | All services for one recipient within a bill |
| 18. Hospice services | All services for one recipient within a bill |

TN NO. 88-12

Supercedes

TN No. 87-07

Approval Date

DEC 22 1988

Effective Date 7/1/88

STATE Rhode Island **OFFICIAL**

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| 19. Extended services to pregnant women | All services for one recipient within a bill |
| 20a. Transportation | All services for one recipient within a bill |
| 20b. Services of Christian Science Nurses | Not provided |
| 20c. Care and services provided in Christian Science sanatoria | Not provided |
| 20d. Skilled nursing facility services for patients under 21 years of age | A bill for services |
| 20e. Emergency hospital services | Not provided |
| 20f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N. | Not provided |
| 21. Case Management services | All services for one recipient within a bill |

TN No. 87-03A
Supercedes
TN No. 79-34

Approval Date 8 MAY 1987 Effective Date 1 JAN 1987

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island

Requirements for Third Party Liability -
Identifying Liable Resources

OFFICIAL

FREQUENCY OF DATA EXCHANGES AND TRAUMA CODE EDITS

Presently the Department of Human Services conducts monthly data exchanges with the Social Security Wage and Earnings Files. Additionally, the Department of Human Services conducts monthly data exchanges with the State Department of Employment Security's Unemployment Compensation Program, Temporary Disability Insurance and new hire files. It should be noted that the State wage information collection agency, the Department of Employment Security, will be implementing SWICA in October, 1988. When SWICA is in place and accessible, the Department of Human Services plans to conduct data exchanges with the SWICA agency.

Relative to the data exchanges with the State Title IVA agency, it should be noted that the Department of Human Services is also the State Title IVA agency and therefore obtains information relative to employed recipients on an on-going basis.

The Workers' Compensation Agency forwards a listing of claims filed with that agency on a monthly basis. These claims are matched against the Department of Human Services eligibility files. Additionally, the Registry of Motor Vehicles will conduct a data exchange with the Department of Human Services eligibility files for the purpose of identifying anyone injured in a motor vehicle accident as a pedestrian, driver, passenger or bicyclist on a semi-annual basis.

Although the Department of Human Services does not utilize ICDCM 9 Diagnostic codes, all claims for payment involving trauma, accident and poisoning are coded with a unique code which encompasses all ICDCM 9 codes 800 thru 999. On a daily basis prior to processing these claims for payment, they are referred to the appropriate specialist to determine the possibility of a third party resource.

Third party liability information obtained from Title IVA applicants and recipients is forwarded on a daily basis to the Division of Medical Services via the AP23 and is posted to the recipient eligibility file.

Third party liability information obtained from applicants and Medically Needy Only recipients; Aged, Blind and Disabled nursing home recipients (non-SSI); Foster Children; categorically eligible medical only recipients; and Three Month Retroactive Eligibility recipients is forwarded to the Division of Medical Services utilizing the AP 757 form which authorizes eligibility and includes third party liability information. Please see Attachment A. The third party liability information is posted to the recipients eligibility file.

TN No. 87-15
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island

OFFICIAL

Requirements for Third Party Liability -
Identifying Liable Resources

Third party liability information relative to SSI applicants and recipients is forwarded to the Division of Medical Services by the Social Security Administration on an SSA 8019 form in accordance with the provision of the Section 1634 Agreement. This information is posted to the recipient eligibility file.

As Rhode Island is an automatic accretion state, the Social Security Administration accretes all eligible SSI recipients to the SMI Buy-In. This information is posted to the recipient eligibility file on a monthly basis.

Additionally, annual data exchanges are conducted with DEERS and Blue Cross/Blue Shield of Rhode Island, a major health insurer covering over 80% of Rhode Island's population, for the purposes of identifying, accessing or recouping from the identified third party liability resource.

FOLLOW UP METHODOLOGY

The Department of Human Services utilizes the following methods of follow up for the purpose of identifying and accessing third party liabilities.

Information obtained from the Social Security Administration Wage and Earning File is forwarded to the appropriate eligibility supervisor in the district offices who assign a worker to verify the information. If earning information is already part of the case record, no further action is taken. If wages were previously unreported, the information is verified and referred to the recipient fraud unit if necessary. If the previously unreported employment provides for third party health insurance, it is reported to the Division of Medical Services on an AP23 form which specifies the type of coverage to include the health insurance membership number and the effective dates of coverage. Please see Attachment B. Upon receipt of the AP23 the information is posted to the recipient eligibility file on a daily basis.

Those Workers' Compensation cases involving Medical Assistance applicants and recipients are identified via the data exchange which is conducted monthly. This information is then forwarded to the applicant's or recipient's case worker who has the 175B form which contains specific third party liability information completed by the applicant or recipient. Please see Attachment C. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to insure recovery of the third party resource.

Those motor vehicle accidents involving Medical Assistance applicants and recipients are identified via the semi-annual data exchange with the Registry of Motor Vehicles. Any matches for which the agency has no information is referred

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State/Territory: Rhode Island

OFFICIAL

Requirements for Third Party Liability -
Identifying Liable Resources

to the applicant's or recipient's case worker who has the 175B form completed by the applicant or recipient. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to ensure recovery of the third party resource.

All claims for payment for medical services other than hospital services with a trauma, poisoning or accident related diagnosis are screened by the appropriate specialist for the possibility of a third party liability. Those claims identified for which there is a possible third party resource are returned to the provider and are referred to the Collection and Recovery Unit. The Collection and Recovery Unit sends the information to the recipient's case worker who has the 175B form completed by the recipient. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to ensure recovery of the third party resource.

Additionally, all hospital claims submitted with a trauma, accident or poisoning diagnosis requires the submittal of a TPL1 form. Please see Attachment D. This form gathers information relative to the circumstances surrounding the reason for seeking medical services and inquires as to whether the client is contemplating legal action and identifies the attorney if appropriate. The TPL1 form is reviewed by the appropriate specialist and is forwarded to the Collection and Recovery Unit. The Collection and Recovery Unit sends the information to the recipient's case worker who has the 175B form completed by the recipient. The completed 175B form is retained in the case record and a copy is forwarded to the Collection and Recovery Unit for appropriate action to ensure recovery of the third party resource.

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SUPPLEMENT TO ATTACHMENT 4.22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Rhode Island

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I)

The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

TN No. 07-010
Supersedes
TN No. NEW

Approval Date 05/14/08

Effective 07/01/2007

RHODE ISLAND DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES

PERSONAL RESOURCE FOR MEDICAL CARE

OFFICIAL

I. IDENTIFYING INFORMATION

CASE NAME _____ AFDC MA DATE _____
 ADDRESS _____ S.S. # _____ (Case #)
 CITY/TOWN _____ TEL. NO. _____

II. MEDICAL INSURANCE PLANS

TYPE OF COVERAGE	Health Insurance Membership Number	Eff. Date of Coverage (If Known)	Resource No Longer Available (Eff. Date)
BLUE CROSS <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Semi-Private <input type="checkbox"/> \$20.-A-Day <input type="checkbox"/> *Co-pay <input type="checkbox"/>			
BLUE SHIELD <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan U <input type="checkbox"/>			
MAJOR MEDICAL <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/>			
I. GROUP HEALTH <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/>			
GROUP PLAN UNDER PROV. HEALTH CENTER, INC. <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/>			
FEDERAL MEDICARE <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/>			
OTHER - Specify _____			

*Co-pay: Semi-private coverage with insuree responsible for \$15.00 per day.

III. MEDICAL NEEDS MET BY OTHER PERSON(S)

PERSON PROVIDING THE SERVICE	SERVICES PROVIDED	Resource No Longer Available (Eff. Date)
(Name) (Address)	HOSPITAL	
(Name) (Address)	PHYSICIAN	
(Name) (Address)	DRUGS	
(Name) (Address)	DENTIST	
(Name) (Address)	OTHER	

Yellow - Medical Standard & Review
 White - Record
 Blue - Recipient

 Signature of Case Aide

R. O. LOCATION _____

AUTHORIZATION FOR MEDICAL ASSISTANCE

Attachment B

Initial Certification DATE _____
 Cert. (previously closed)
 (previously denied)
 Certification CASE NUMBER: _____
 MA _____

D. FLEXIBLE TEST (Circle One)
 YES (Code 5) NO (Code 6)
 If Yes, show use of \$ _____
 excess income below: _____

OFFICIAL

A. PERSONAL INFORMATION
 1. Name: Last _____ First _____ Middle Initial _____

2. Mail To: Number _____ Street or Avenue _____

3. City/Town _____ State _____ Zip Code _____

Former Name of Address, if Changed: _____

4. Date of Birth _____ 5. Social Security Claim or Account Number _____

6. Date Eligibility Begins _____ 7. Date Eligibility Expires _____

8. Prior Category Numbers _____ 9. Cross Reference Number (s) _____

10. Sex: (Circle One) 1. Male 2. Female 11. (Office Use Only) _____

12. Marital Status (Circle One)
 Never Married, 2. Widowed, 3. Married, living with spouse,
 4. Divorced, 5. Separated 6. Not Applicable (child)

13. Eligibility Factor (Circle One)
 1. 65 & Over 2. Blind 3. Disabled 4. Death
 5. Incapacity 6. Absence 7. Unemployed

Total Number of Eligible Persons _____
 Total Number of Eligible Children _____

14. Health Insurance (Circle One in a to d below):
 a. Social Security Part B. 1. Yes 2. No
 b. Blue Cross 1. Yes 2. No # _____
 c. Physicians Service 1. Yes 2. No # _____
 d. Other: 1. Yes 2. No If yes, complete:
 Name of Company _____ Policy Number _____

B. ASSETS
 1. Does applicant own his own home? (Circle One) 1. Yes 2. No.
 2. a. Real Estate \$ _____
 b. Cash \$ _____
 c. Stocks & Bonds \$ _____
 d. TOTAL \$ _____
 3. Life Insurance \$ _____
 Eligible Personal Property \$ _____

C. ANNUAL INCOME
 1. Net Earned Income \$ _____ 2. Social Security Benefits \$ _____
 3. Other Government Benefits \$ _____ 4. All Other Income \$ _____
 5. Total Income \$ _____

E. FOR FAMILY CASES ONLY
 NAME AND BIRTHDATE:

Spouse: _____
 Children: _____

CHANGES	NAME	BIRTHDATE
Parent Added		
Parent Removed		
Child Added		
Child Removed		
Previous Unborn		

F. **ELIGIBLE** - The above - named are certified as eligible to receive Medical Assistance benefits.

G. **INELIGIBLE** - (Circle one)
 1. Closing: Eff. Date _____
 2. Rejection: _____

- REASON:** (Circle One)
 1. Does not have category characteristics.
 2. Assets are in excess of maximum.
 3. Income is in excess of maximum.
 4. Eligible for money payment.
 5. Death: Date _____
 6. Form not returned
 7. Other: (Specify) _____

SIGNATURE _____
 EIN _____ TITLE _____

MASTER FILE	KEY PUNCH	VERIFY

ASSIGNMENT OF COLLATERAL ASSISTANCE

Case Name _____ Case Number _____

Workers' Compensation Yes No

OFFICIAL

KNOW ALL MEN BY THESE PRESENTS:

WHEREAS: I, _____ SSN _____
on behalf of _____ SSN _____
(injured party)

in consideration of medical care services and support to be furnished to me by the Department of Human Services under the provisions of 40-6-7, 40-6-8 and/or 40-8-4 of the General Laws of Rhode Island which assistance of medical care is necessary by reason of accident, injury, or illness sustained on _____ for which the following named third party may be liable: _____ (date)

Name _____
Address _____

and for which said accident, injury, or illness there are monies expected to be paid and provided to me by said _____, or on his/her behalf by: _____ (third party)

Insurance Company _____
Address _____

NOW THEREFORE, I, _____, do hereby assign as required by the above-named statutes or programs to the Department of Human Services an amount of money equal to the amount of medical care services and support furnished to me under the aforementioned categories of assistance as a result of said accident, injury, or illness.

This assignment and agreement shall not operate as a lien against any amounts due me which are in excess of monies paid by the department for which medical care services and support were given.

I acknowledge that I have read this agreement or that it has been read to me, and I thoroughly understand its meaning before affixing my signature, that the statements herein made by me are true to the best of my knowledge and belief and are made under the penalties of perjury.

WITNESS MY SIGNATURE THIS _____ day of _____, 198 ____.

*Signature _____

Address _____

Notary or Witness Signature _____

If Attorney, Name _____

Address _____

Agency Representative _____

Office Location _____

*Requires original signature on all six (6) copies.

OFFICIAL

Patient: _____
Parent or Guardian: _____
Address: _____
Medical Assistance Number: _____

Where Treated:
Inpatient: _____
Outpatient: _____
Date: _____

In view of the above treatment which appears to have resulted from a condition caused by an injury, the Rhode Island Medical Assistance Program requires submission of the information below before any payment can be made by the State of Rhode Island.

1. WAS HOSPITAL TREATMENT CAUSED BY AN ON-THE-JOB INJURY? Yes ___ No ___
If yes, where is patient employed? _____

1. If not injured on the job, where did the injury occur?
 Home Highway Other _____
Date: _____ Describe what happened: _____

Do you have any insurance to cover this injury? Yes ___ No ___

2. Was another party responsible for the injury? Yes ___ No ___
If yes, complete remainder of form.

a. Other Party Other Party's Insurance Co.
Name _____ Name _____
Address _____ Address _____

b. Do you intend to make a claim against the other party or his insurance company for damages arising from the injury?
Yes ___ No ___

c. Have you retained an attorney for the enforcement of your rights? Yes ___ No ___

If yes, please list his name and address below:

Name _____ Address _____

If you answered no to either b or c above and later file a claim, you are required to notify the Medical Assistance Program.

I agree to assign any rights I now have or may have to collateral benefits received as a result of accident, injury, or illness, equal to the amount of medical care or assistance furnished to me.

Signed: _____ Date: _____
Patient or Guardian

STATE OF RHODE ISLAND

Requirements for Third Party Liability-
Payment of Claims

The Rhode Island Medical Assistance Program seeks reimbursement in all instances regardless of amount involved except in specific circumstances in accordance with federal law as detailed below:

1. Rhode Island will use a standard coordination of benefits cost avoidance when processing claims for prenatal services including labor and delivery, and postpartum care claims. If the State Medicaid Agency has determined a third party is liable for a prenatal claim, the agency will reject the claim and return the claim to the provider requesting the provider seek payment from the legally responsible third party.

The provider must bill the liable third party for the cost of care. If after the provider bills the liable third party and a balance remains, or the claim is rejected for a substantial reason, the provider can resubmit the claim to the State Medicaid Agency for payment of the balance up to the maximum Medicaid payment amount established in the fee schedule authorized by the state plan for the service billed.

2. Effective December 1, 2021 the State Medicaid Agency shall make payments without regard to third party liability for claims related to pediatric preventive services unless the State Medicaid Agency has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days in paying the claim
3. Effective December 1, 2021 the State Medicaid Agency may pay a claim related to child support enforcement without regard to third party liability for up to 100 days after a claim is submitted.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Rhode Island

Citation	Condition or Requirement
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Section 1906 of the Act	State Method on Cost-Effectiveness of Employer-based Group Health Plans
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Mandatory Premium Assistance Program

The following methodology is used to determine the cost effectiveness of an employer-based group health plan for individuals and families subject to enrollment in Medicaid Managed Care.

Introduction

RIte Share is the State's premium assistance program established under the authority of Section 1906 of the Act. Beneficiaries subject to RIte Share include: children, families, parents and caretakers eligible for Medicaid, or the Children's Health Insurance Program (CHIP) covered under the CHIP State Plan, and childless adults between the ages of nineteen (19) and sixty-four (64) who are not receiving or eligible to receive Medicare. All beneficiaries eligible for RIte Share must be enrolled, or be eligible for enrollment, in one of the State's Medicaid Managed Care delivery systems. The state provides a subsidy payment for qualified health insurance plans offered by employers. A qualified plan must meet minimum benefit requirements and maximum cost sharing requirements (deductibles, co-payments and coinsurance), and be determined cost effective.

The subsidy payment is equal to the employee's share of the monthly premium and is generally paid directly to the member. EOHHS ensures that individuals enrolled in RIte Share have access to all Medicaid covered services by directly paying Medicaid enrolled providers for services and cost sharing requirements (generally up to the Medicaid allowable amount) not covered in the commercial plans, as well as services that exceed the coverage limitations of commercial plans.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Rhode Island

Citation	Condition or Requirement
Section 1906 of the Act	State Method on Cost-Effectiveness of Employer-based Group Health Plans

Cost Effectiveness – Concept

On average, the total cost for providing Medicaid covered services through RIte Share must be less than the cost of providing such services through Medicaid Managed Care.

Cost effectiveness is determined in the aggregate by Medicaid Managed Care plan type (i.e., individual, individual pregnant woman, child only, or family). This reduces the administrative burden for the applicant, the employer, and the state. This method is effective in ensuring that the cost to EOHHS for those enrolled in the premium assistance program is less than enrolling those same individuals or families in Medicaid Managed Care.

In order for the state to determine that an employer plan is cost effective, the employee's monthly premium share plus any Medicaid covered services not covered in the commercial plan (all cost sharing wrap and benefits/services covered under Medicaid Managed Care) plus administrative costs, must be less than the average capitation payment (based on age, sex, and average family size) for a Medicaid Managed Care individual. There are (4) four coverage types and income thresholds that the state utilizes to evaluate cost effectiveness for an employer plan:

1. Family coverage where all family members are Medicaid eligible (income less than or equal to one hundred thirty six percent (136%) of the federal poverty guidelines (FPL)- where entire family is Medicaid eligible);
2. Family coverage where children in the family are Medicaid eligible (income greater than one hundred and thirty-six percent (136% FPL), and less than or equal to two hundred and sixty one percent (261% FPL) for families with children provided cost effective to also pay for parents;

3. Family coverage where pregnant women are eligible, i.e., income greater than one hundred and thirty-six percent (136%), and less than or equal to two hundred fifty three percent (253%) of FPL);

Revision HCFA-PM-91-8 (MB)
October 1991

Attachment 4.22-C
Page 3

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Rhode Island

Citation	Condition or Requirement
Section 1906 of the Act	State Method on Cost-Effectiveness of Employer-based Group Health Plans

4. Individual coverage where only the employee is Medicaid eligible (133% FPL) (Medicaid Expansion).

All the above listed FPL guidelines are not inclusive of the five percent (5%) income disregard.

Methodology

The state uses a calculator to determine cost effectiveness for each type of coverage. The calculator takes into account the actuarial values of all applicable premiums, cost sharing wrap (including deductibles and coinsurances amounts), benefits wrap (based on ESI benefits maximums and Medicaid Managed Care only benefits) and RItE Share administrative costs, compared to an Employer Sponsored Insurance (ESI) plan when determining cost effectiveness.

The process for determining cost effectiveness is outlined below:

1. Prospectively determine the average value (cost) of Medicaid Managed Care capitation for the time period and population under consideration;
2. Identify and determine the average actuarial value(s) of the cost sharing and benefit differences between Medicaid Managed Care and RItE Share approved employer sponsored insurance (ESI) plans– including differences in copays, deductibles, coinsurances amounts, benefit maximums and Medicaid Managed Care only benefits to determine the benefits to be wrapped.
3. Determine and allocate net operational costs to administer RItE Share.
4. Calculate the subsidy threshold, as the average Medicaid Managed Care value minus the actuarial value of the benefit difference determined in step 2 and the net operational costs determined above in step 3.

Cost Sharing Wrap

TN No. 19-003
/2019
Supersedes
TN No. 92-07

Approval Date 06/25

Effective Date: July 1, 2019

RIt Share ensures that members do not need to pay out of pocket costs that exceed nominal cost sharing in the following ways:

Revision HCFA-PM-91-8 (MB)
October 1991

Attachment 4.22-C
Page 4

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Rhode Island

Citation	Condition or Requirement
Section 1906 of the Act	State Method on Cost-Effectiveness of Employer-based Group Health Plans
	<ol style="list-style-type: none">1. If a member obtains care from a provider that is both a Medicaid participating provider and participating in the ESI network, Medicaid pays secondarily to the ESI plan up to the Medicaid negotiated rate2. If a member intends to obtain care from an ESI provider that is not participating with Medicaid, members are instructed to:<ol style="list-style-type: none">a. Contact EOHHS so that EOHHS may negotiate with such provider to cover cost sharing wrap.b. If the state cannot reach agreement with such provider through the fee-for-service network, the state will review the case to determine if the member meets "good cause" for disenrolling from the ESI plan in order to maintain continuity or access to care and ensure that the beneficiary does not incur out-of-pocket costs for cost sharing. The state ensures continuity of care for these individuals when disenrolled from RItshare by enrolling them with a Medicaid Managed Care Organization (MCO) that may be able to contract with the provider at issue. Reasons for "good cause" may include, but are not limited to the following:<ol style="list-style-type: none">i. the member is being treated for a condition by this provider,ii. there is a long-standing provider/beneficiary relationshipiii. the member cannot access medically necessary care.c. In the case that good cause is determined, the member will be notified and enrolled in the MCO in which the provider in question participates. In the case that none of the Medicaid MCOs contract with the provider in question, the member may choose an MCO, and the MCO may work to contract with the provider.

Revision: HCFA-PM-86-9 (BERC)
MAY 1986

ATTACHMENT 4.32-A
Page 1
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Rhode Island

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

There is a written agreement between the Rhode Island Department of Human Services (DHS) and the Rhode Island Department of Employment Security (DES) to exchange information for purposes of establishing an income and eligibility verification system in accordance with the provisions of Section 2651 of the Deficit Reduction Act of 1984 (DEFRA) which amended Title XI of the Social Security Act and Section 303 of Title III of the Social Security Act. Further requirements for the system were published as Secretary of Health and Human Services and Secretary of Labor final regulations in the FEDERAL REGISTER February 28, 1986, at 42 CFR 431, 435 and 20 CFR 603. In accordance with the above law and regulations and Chapter 28-42 of the Rhode Island Employment Security Act, DHS and DES agree as follows:

DHS Actions

DHS will prepare a computer tape record, following Standardized Format Type 1, as defined in the Standardized Formats Guidelines and Procedures developed by the Department of Health and Human Services, to be submitted to the DES on or about the 15th and 30th of each month, requesting current unemployment insurance benefit data as required in Standardized Format Type 3.

DES Actions

DES will prepare an initial output tape (which will consist of Standardized Format Type 3 following the instructions and guidelines in the Standardized Formats and Procedures) within 10 weeks of receipt of the initial computer tape. Subsequent output tapes will be prepared within 5 working days of receipt of each computer tape.

Matters of employee bonding, confidentiality, administrative costs, and nondiscrimination requirements are addressed within the agreement.

TN No. 86-10
Supersedes
TN No. _____

Approval Date 09/10/86

Effective Date 9/30/86

HCFA ID: 0123P/0002P

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ATTACHMENT 4.32-B

Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: RHODE ISLAND
INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
TARGETING METHODOLOGY

STATE FOLLOW-UP PLAN FOR INFORMATION ITEMS RECEIVED FROM MATCHING OPERATION UNDER THE INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS).

The categories of IEVS information items excluded from follow-up and the State's justification for excluding such categories from follow-up are defined below. Medical Assistance cases which fall below the identified tolerance levels are excluded from follow-up.

A. SOCIAL SECURITY BENEFITS MATCH:

I. Community Cases

- a. \$50.00 annual tolerance for discrepancy between amount on the DHS file and an adjusted yearly Bendex file for all community-based cases with the exception of Flexible Test of Income cases. \$1.00 annual tolerance for Flexible Test of Income cases which have achieved Medical Assistance eligibility as a result of meeting a spend-down liability.
- b. Experience has demonstrated that a lower tolerance would generate a large number of matches with follow-up resulting in a small percentage of cases whose eligibility would be affected.

II. Long Term Care Cases

- a. \$1.00 annual tolerance for discrepancy between amount on the DHS file and an adjusted yearly Bendex file for all Nursing Facility, Intermediate Care Facility-Mental Retardation, and Home & Community Based Services Waiver cases.
- b. Tolerance allowed as rounding techniques used by the different programs cause insignificant variations. The tolerance is set low as income is used to determine the liability applied to cost of care.

TN No. 90-03
Supersedes
TN No. NEW

Approval Date: DEC 04 1990 Effective Date: 4/1/90

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: RHODE ISLAND
INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
TARGETING METHODOLOGY

B. SOCIAL SECURITY WAGE MATCH:

I. Community Cases

- a. \$1360 per year per employee which represents eight weeks of employment at the minimum wage. (Currently \$4.25 x 40 hrs. x 8 wks.)
- b. Tolerance originally set at \$150 per employee per year. Calendar year 1989 match resulted in 722 hits with only 11 closures and demonstrated that this tolerance is not cost effective. Tolerance is now to be tested as described above since individuals employed less than 8 weeks/year were only loosely connected with the work force and not likely to be currently employed or to have past or present earnings in excess of the MNIL. Also, this tolerance is comparable to that employed by other states in the region. Additionally, Rhode Island will be identifying current earners through SWICA.

II. Long Term Care Match

- a. No follow-up on match conducted.
- b. Experience has demonstrated that the likelihood of individuals in nursing facilities being employed would not justify the expense of processing a match. Administrators of mental retardation facilities submit monthly earned income reports on employed MR individuals as a quality control corrective action.

C. UNEMPLOYMENT COMPENSATION BENEFIT MATCH:

I. Community Cases

- a. Tolerance is \$0.00.
- b. Matched dollar for dollar.

II. Long Term Care Cases

- a. Tolerance is \$0.00.
- b. Matched dollar for dollar.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: RHODE ISLAND
INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
TARGETING METHODOLOGY

D. INTERNAL REVENUE SERVICE UNEARNED INCOME MATCH:

I. Community Care Cases

- a. \$200.00 annual tolerance for Medically Needy.
\$100.00 annual tolerance for Categorically Needy for Aged, Blind, or Disabled characteristics.
\$50.00 annual tolerance for Categorically Needy Foster Care and AFDC characteristics.
- b. The basic asset limit for Medically Needy individuals and families is \$4,000. The basic asset limit for Categorically Needy individuals is \$2,000 and for Categorically Needy families is \$1,000. Based on a plausible 6% interest rate, the tolerances would target those with interest-generating resources exceeding \$3300, \$1650, and \$825 respectively while allowing a reasonable buffer. The potential for additional unreported resources exceeding the limits if taken in aggregate exists. However, that potential remains regardless of the amount of tolerance if the additional assets are not of an interest-generating nature. Experience has demonstrated that interest earnings of less than the tolerances indicate resources within the program asset limits.

II. Long Term Care Cases

- a. \$200.00 annual tolerance for Medically Needy.
\$100.00 annual tolerance for Categorically Needy for Aged, Blind, or Disabled characteristics.
- b. Same justification as in D., I., b. above.

TN No. 90-03
Supersedes
TN No. NEW

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

OFFICIAL

Medical Assistance Eligibility Cards are made available to eligible homeless individuals and families at the district office which received the application, or are mailed to a mailing address provided by the recipient.

TM No. 87-15
Supersedes
TM No. 87-04

Approval Date 17 FEB 1988

Effective Date 10/1/87

HCFA ID: 1080P/0020P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: RHODE ISLAND

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

The only Rhode Island laws governing the area of advance directives are Title 23, Chapter 4.10 entitled *Health Care Power of Attorney*, and Title 23, Chapter 4.11 entitled *Rights of the Terminally Ill Act*. Chapter 4.10 concerns the use of a statutory form of durable power of attorney and Chapter 4.11 establishes a procedure whereby terminally ill persons could have life-sustaining procedures withheld or withdrawn. This description is provided in summary of and not in substitution for a careful reading of the statutory provisions cited herein.

Statutory Form Durable Power of Attorney for Health Care

The Statutory Form Durable Power of Attorney for Health Care gives the agent full power and authority, except to the extent that there are limits provided by law, to make health care decisions consistent with the desires of the individual executing the document. The power is subject to any statement of desires and any limitation included in the document by the principal.

The person executing the durable power of attorney for health care must be at least eighteen (18) years of age and a resident of the state of Rhode Island. Notwithstanding the document, the principal retains the right to make medical and other health care decisions as long as informed consent can be given with respect to the particular decision and no treatment may be given or health care stopped or withheld over the objection by the principal at the time.

For purposes of the document "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

A court can take away the power of the agent to make health care decisions if the agent (1) authorizes anything that is illegal, (2) acts contrary to the known desires of the principal, or (3) where the desires of the principal are unknown, does anything that is clearly contrary to the best interests of the principal.

Unless specified for a specific period the durable power of attorney for health care exists until revoked by the principal and the agent's power and authority cease upon death of the principal. The principal may revoke the authority of the agent by notifying the agent or the treating doctor, hospital, or other health care provider orally or in writing of the revocation.

The agent has the right to examine and consent to the disclosure of medical records unless the right is limited by the document.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: RHODE ISLAND

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The document must be witnessed by two (2) qualified witnesses who are present when the principal signs or acknowledges signing the document. Any additional pages attached to the form must be individually signed and dated at the same time the principal dates and signs the durable power of attorney. None of the following may be used as a witness: (1) the person designated by the principal as the agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility.

A declaration, under penalty of perjury, must be made by one or the other of the witnesses that the principal is known to the witness; that the principal signed or acknowledged the durable power of attorney in the presence of the witness and appeared of sound mind and under no duress; that the witness is not the person appointed as attorney in fact; that the witness is not one of the above identified as ineligible to be a witness. An additional declaration, under penalty of perjury, must be made by one or the other of the witnesses that the witness is not related to the principal by blood, marriage, adoption, and, to the best of the witness's knowledge, the witness is not entitled to any part of the estate of the principal under an existing will or by operation of law.

Rights of the Terminally Ill Act

This Act recognizes the right of an adult person to make a written declaration instructing his/her physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition and establishes a procedure whereby terminally ill persons can have life-sustaining procedures withheld or withdrawn.

A competent individual eighteen (18) years of age or older may at any time execute a declaration governing the withholding or withdrawal of life-sustaining procedures. The declaration must be signed by the declarant, or another at the declarant's direction in the presence of two (2) subscribing witnesses who are not related to the declarant by blood or marriage. A declaration has operative effect only when (1) the declaration is communicated to the attending physician, and (2) the declarant is determined by the attending physician to be in a terminal condition, and (3) the declarant is unable to make treatment decisions.

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TN No. NEW

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JUNE 1995

Attachment 4.35-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

TN No. 95-019

Supersedes

TN No. 90-15

Approval Date:

DEC 11 1995

Effective Date: 7/1/95

Revision: HCFA-PM-95-4 (HSQR)
JUNE 1995

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

TN No. 95-019

Supersedes

TN No. New

Approval Date: DEC 11 1995 Effective Date: 7/1/95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-C

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-019

Supersedes

TN No. New

Approval Date: DEC 11 1995 Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-019

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OFFICIAL

Attachment 4.35-E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-019

Supersedes

TN No. New

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JUNE 1995

Attachment 4.35-F

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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JUNE 1995

Attachment 4.35-G

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: RHODE ISLAND

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-019

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TN No. New

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JUNE 1995

Attachment 4.35-H

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

TN No. 95-019

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OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

CRITERIA FOR THE APPLICATION OF SPECIFIED REMEDIES FOR
SKILLED NURSING AND INTERMEDIATE CARE FACILITIES
(When and how each remedy is applied, the amounts of any fines,
and the severity of the remedies)

1. The Rhode Island Department of Human Services, pursuant to departmental regulations, provides no Medical Assistance payment for patients admitted to a nursing facility subsequent to a finding by the Rhode Island Department of Health that the facility does not comply with the requirements of Sections 1919 (b), (c), and (d).
2. The Rhode Island Department of Health is directed by R.I.G.L. 23-17-10.3 et seq. to assess and collect with interest an administrative penalty. Such administrative penalty relates to severity of the compliance failure, the resultant actual or potential damage, whether previous penalties have been assessed, and other factors. Each occurrence of a violation and/or day a violation exists constitutes a separate and distinct violation for purposes of penalty assessment.
3. The Rhode Island Department of Health is directed by R.I.G.L. 23-17-10.6 et seq. to petition Superior Court to appoint a receiver to protect the health, safety, and well being of the facility's residents when the Department of Health determines that the facility is being managed in a manner detrimental to the health, safety, and well being of the residents of the facility. Such receiver has the statutory authority to operate the facility while improvements are made to bring the facility into compliance.
4. The Rhode Island Department of Health is directed by R.I.G.L. 23-17-10.6 et seq. to petition Superior Court to appoint a receiver to protect the health, safety, and well being of the facility's residents when the Department of Health determines that the facility is being managed in a manner detrimental to the health, safety, and well being of the residents of the facility. Such receiver has the statutory authority to close the facility and effectuate the safe and orderly removal and placement of its patients.

TN No. 90-15
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TN No. NEW

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January 1993

ATTACHMENT 4.39
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

DEFINITION OF SPECIALIZED SERVICES

SPECIALIZED SERVICES

Mental Illness

Specialized services do not have to be provided by nursing facilities. The term "Specialized Services" is equated with the level of care provided in psychiatric hospitals, or other intensive programs staffed with trained mental health professionals on a 24-hour/day basis. The patient's care follows the aggressive implementation of a treatment plan developed by an interdisciplinary team including a physician and other qualified mental health professionals and incorporates therapies supervised by these professionals. Treatment is aimed at diagnosing and reducing behavioral symptoms to improve the patient's level of functioning to a point that permits a reduction in intensity of services as soon as possible. While some of these services may be the same as those required to be provided by the nursing facility, it is their intensive level that sets them apart.

Mental Retardation

A continuous program for each client, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward: 1) the acquisition of the behaviors necessary for the person to function with as much self determination and independence as possible; and, 2) the prevention or deceleration of regression or loss of current optimal functional status. Specialized Services does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous specialized services program.

TN No. 94-025

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3/1/95

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January 1993

ATTACHMENT 4.39-A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

CATEGORICAL DETERMINATIONS

The State Medicaid authority may make an advance group determination in conditions where:

1. Care of a terminal illness with a life expectancy of less than six months and requires NF care.
2. Care of a severe illness which results in a level of impairment so severe that this individual could not be expected to benefit from specialized services. "Severe illness" includes but is not limited to, comatose, ventilator dependent, functioning at the brain stem level, chronic obstructive pulmonary disease, Huntington's disease, Parkinson's disease, amyotrophic lateral sclerosis and congestive heart failure.
3. Provisional admissions with documentation of recommended NF medical and psychiatric follow-up; pending further assessment in case of delirium where an accurate diagnosis cannot be made until delirium clears, no more than 30 days after NF admission.
4. Provisional admissions pending further assessment in emergency circumstances requiring protective services to assist in removing an individual from a situation in which s/he is being abused, neglected, and/or exploited. Placement in a NF is not to exceed 7 days.
5. Very brief and finite stays of up to 30 days to provide respite to in-home caregivers to whom the individual with MI or MR is expected to return following the brief NF stay.

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ATTACHMENT 4.42-A

Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF RHODE ISLAND

Rhode Island will re-assess an entity's compliance to Section 1902 (a)(68) of the Social Security Act by having entities certify at the time of enrollment and at re-enrollment, and no later than every two years, that they are in conformance with Section 1902 (a) (68) of the Act. Entities will be notified on bi-annual basis and within the first month of the quarter of reenrollment that they will need to submit a certification document that will be filed with the entity's enrollment information.

The State will identify entities that receive or make annual Medicaid payments of at least \$5 million in expenditures in calendar 2006 and will require them to sign a Certification of Compliance Form for 2007. The State will notify entities by August 31, 2007 and certifications must be received by DHS within 45 days of notification.

The State will use a self-declaration method to ensure compliance to the Act by requiring providers to sign a Certification of Compliance Form. The state will conduct on an annual basis a desk audit of at least 2% of the entities to ensure compliance to the act. The state will review the actual policies, procedures and employee handbooks during the desk audits.

TN No: 07-004

Supercedes

TN No: New

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