STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

11/20/2018 PUBLIC NOTICE OF PROPOSED AMENDMENT TO RHODE ISLAND MEDICAID STATE PLAN

In accordance Rhode Island General Laws 42-35, notice is hereby given that the Executive Office of Health and Human Services (EOHHS) proposes to make the following amendment to the Rhode Island State Plan under Title XIX of the Social Security Act:

RIte Share Premium Assistance Program

EOHHS is seeking federal authority to update the RIte Share Premium Assistance Program to include childless adults between the ages of nineteen (19) and sixty-four (64) who are not receiving, or eligible to receive Medicare. These individuals must be enrolled, or be eligible for enrollment, in one of the State's managed care delivery systems. This change would result in a savings of approximately $2.5 million all funds. The proposed effective date of this amendment is January 1, 2019.

This proposed amendment is accessible on the EOHHS website (www.eohhs.ri.gov) or available in hard copy upon request (401-462-6348 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by December 20, 2018 to Melody Lawrence, Executive Office of Health and Human Services, 3 West Rd, Cranston, RI, 02920, or Melody.Lawrence@ohhs.ri.gov.

In accordance with the Rhode Island General Laws 42-35-3, an oral hearing will be granted on the proposed State Plan Amendment if requested by twenty-five (25) persons, an agency, or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within fourteen (14) days of this notice.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or handicap in acceptance for or provision of services or employment in its programs or activities.

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

The state employs two distinct methodologies for determining the cost effectiveness of an employer based group health plan: one is used for individuals eligible under coverage groups that receive medical benefits through a fee-for-service system; and the second is used for individuals and families eligible under coverage groups that receive medical benefits through Medicaid Managed Care.

The following methodology is used to determine the cost-effectiveness of an employer-based group health plan for individuals that receive benefits as fee-for-service:

1. POLICY INFORMATION: Obtain information on the group health plan available to the recipient. This information must include the effective date of the policy, exclusions to enrollment, covered services under the policy, and premiums paid by the employee.
2. COVERAGE FOR MEDICAID COSTS: The Executive Office of Health and Human Services (EOHHS) has established total annual Medicaid costs of persons like the recipient (age, category or assistance), based on available data.
3. COST-EFFECTIVENESS REVIEW: EOHHS reviews the policy to determine the amount saved by the specific policy provisions compared to the average cost for the type of recipient as determined in 2., above. Only the costs of services covered by the insurance policy are included. The total amount that the EOHHS will save under the health insurance policy's provisions is compared against the sum of the following:
    a. The premium cost, including the cost of premiums for those ineligible for Medicaid who must be included for the policy to be in effect; and
    b. The cost to EOHHS for paying co-insurance, cost sharing and deductible factors for the Medicaid eligible individual(s), if any are imposed under the policy; and
    c. Administrative costs estimated to be $135 per determination.

If the projected amount that would be paid by the EOHHS absent the existence of the policy is greater than the sum of costs a., b., and c., above, the policy is determined to be cost effective.

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

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), 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 up to the Medicaid allowable amount not covered in the commercial plans, as well as services that exceed the coverage limitations of commercial 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. This will reduce 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.

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

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 and services covered under Medicaid Managed Care) must be less than the average capitation payment for an average Medicaid Managed Care individual or family. There are three (3) cost effectiveness determinations for each 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));
2. Family coverage where only children and/or pregnant women in the family are Medicaid eligible (for families, income greater than one hundred and thirty-six percent (136%), and less than or equal to, two hundred and sixty one percent (261%); for pregnant women, income greater than one hundred and thirty-six percent (136%), and less than or equal to two hundred fifty three percent (253%) of FPL);
3. 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 to allow for minor fluctuation in income.

Methodology

1. Prospectively determine the average value (cost) of Medicaid Managed Care for the time period and population under consideration
2. Identify and determine the average actuarial value(s) of the benefit differences between Medicaid Managed Care and RIte Share approved employer sponsored insurance (ESI) plans most prevalent in the market – including differences in copays, deductibles, coinsurances amounts, benefit maximums and Medicaid Managed Care only benefits.
3. Determine and allocate net operational costs to administer RIte Share.
4. Calculate the average 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. The value of the difference determined in step 2 shall be allocated to make Medicaid eligible individuals covered through RIte Share approved ESI plans whole on a Medicaid Managed Care benefits equivalent basis.

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

RIte Share Buy-In

Families whose income is between 150-250% of federal poverty level, in which the non-Medicaid eligible adult is employed by an employer whose family health insurance coverage is determined cost effective, may be enrolled into the RIte Share Buy-in program. This Buy-in group is charged a monthly premium by the State that is no greater than 5% of income. The monthly premium will be deducted from the policy holder's subsidy payment. Non- Medicaid eligible household members are not eligible to receive Medicaid wrap around benefits.

Revision: HCFA – PM – 91 – 8 (MB) OMB No.
October 1991

State/Territory: Rhode Island

Citation
42 CFR 433.151(a)
50 FR 46652

4.22 (continued)

(f) The Medicaid Agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with at least one of the following:
(Check as appropriate.)

☒ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

☐ Other appropriate State agency(s) –

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☐ Other appropriate agency(s) of another State –

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☐ Courts and law enforcement officials.

42 CFR 433.151(b)
50 FR 46652

(g) The Medicaid agency meets the requirements of 42 CFR 433.153 and 433.154 for making incentive payments and for distributing third party collections.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

☐ The Secretary's method as provided in the State Medicaid Manual, Section 3910

☒ The State provides methods for determining cost effectiveness on Att. 4.22-C.