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TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 30 – MEDICAID FOR CHILDREN, FAMILIES AND AFFORDABLE CARE ACT (ACA) ADULTS

SUBCHAPTER 05 – SERVICE DELIVERY OPTIONS

PART 2 – Medicaid Managed Care Delivery Options

2.1 RIte Care Overview

A. RIte Care was initially established as a statewide managed care demonstration project in 1994 under a Medicaid Title XIX Section 1115 waiver. The project's goal was to use a managed care delivery system to increase access to primary and preventative care for certain individuals and families who otherwise might not be able to afford or obtain affordable coverage. Medicaid members participating in RIte Care are enrolled in a managed care organization (MCO). EOHHS contracts with MCOs to provide these health services to members at a capitated rate (fixed cost per enrollee per month). RIte Care managed care plans serve the following MACC coverage groups: families, children, parent caretakers, foster children (DCYF custody), and pregnant women.

B. Individuals and families who have access to employer-sponsored health insurance plans are evaluated for participation in the RIte Share Premium Assistance Program in accordance with provisions contained in "RIte Share Premium Assistance Program" (Part 3 of this Subchapter). Adults in these families are required to enroll any Medicaid-eligible family members in a RIte Share approved plan as a condition of retaining Medicaid eligibility. Medicaid is provided on a fee-for-service basis for certain beneficiaries in the populations RIte Care plans serve.

2.2 Scope and Purpose

A. The purpose of this Rule is to describe the RIte Care delivery system and the respective roles and responsibilities of EOHHS and the individuals and families that are receiving affordable coverage through a RIte Care MCO.

B. This Rule is consistent with the Federal managed care Rules (42 C.F.R. Parts 431, 433, 438, *et seq*., Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule) published in March 2016 that contain, among other provisions, certain mental health parity requirements added to the Public Health Service Act (PHS Act) by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of

2008 (MHPAEA) ((Pub. Law 110–343), enacted on October 3, 2008). Such parity provisions (42 C.F.R. Parts 438, 440, 456, and 457) prohibit health plans from applying treatment limitations on mental health and substance use disorders (SUDs) that would be more restrictive than those applied to medical/surgical benefits.

2.3 Program Management

Title XIX of the U.S. Social Security Act provides the legal authority for the Rhode Island Medicaid program. The RIte Care program operates under a waiver granted by the Secretary of Health and Human Services (HHS) pursuant to Section 1115 of the Social Security Act. The RIte Care Managed Care Consumer Advisory Committee was established by Executive Order in February 1994. The Committee is available to RIte Care consumers to address suggestions, complaints, or related issues.

2.4 Definitions

A. For the purposes of this Rule, the following definitions apply:

1. “Advance practice provider” or “APP” means and includes physician assistants, certified nurse practitioners, psychiatric clinical nurse specialists, and certified nurse midwives. These individuals must maintain compliance with all applicable statutes and regulations and not exceed their scopes of practice.

2. “Appeal” means a formal request by a covered person or provider for reconsideration of a decision, such as a utilization review recommendation, a benefit payment, or administrative action.

3. “Applicant” means a person seeking Medicaid coverage under this Part, in accordance with the provisions established in Rhode Island General Laws and Public Laws.

4. “Care manager” means a nurse or social worker with specialized training in providing care management services.

5. “Complementary alternative medicine” or “CAM” means treatment from a chiropractor, acupuncturist, and/or massage therapist.

6. “Days” means calendar days.

7. “Employer sponsored insurance” or “ESI” means health insurance or a group health plan offered to employees by an employer. This includes plans purchased by small employers through HealthSourceRI.

8. “Enrollee” means a Medicaid member or “beneficiary” who is enrolled in a Medicaid managed care plan.

9. “Executive Office of Health and Human Services" or "EOHHS” means the state agency established in 2006 under the provisions of R.I. Gen. Laws Chapter 42-7.2 within the executive branch of State government and serves as the principal agency for the purposes of managing the Departments of Children, Youth, and Families (DCYF); Health (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The EOHHS is designated as the “single state agency,” authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq.*) and, as such, is legally responsible for the program/fiscal management and administration of the Medicaid Program.

10. “Grievance” means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to:

    a. Quality of care or services provided;

    b. Aspects of interpersonal relationships such as rudeness of a provider or employee;

    c. Failure to respect the member’s rights regardless of whether remedial action is requested;

    d. Right to dispute an extension of time proposed by the MCO to make an authorization decision.

11. “In lieu of services” means cost effective alternative services/equipment, even where those services/equipment are not identified as an in-plan benefit, when the use of such alternative services/equipment are medically appropriate and cost effective, such as the purchase of an air conditioner, where clinically appropriate, which helps a beneficiary avoid hospitalization.

12. “Limited English proficiency” or “LEP” means that enrollees do not speak English as their primary language and may have a limited ability to read, write, speak, or understand English and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

13. “Managed care organization" or "MCO” means a health plan system that integrates an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and emphasizes preventive and primary care.

14. “Medicaid affordable care coverage group” or "MACC" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility as follows:

a. Families and Parents/Caretakers with income up to one hundred forty-one percent (141%) of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of eighteen (18) or nineteen (19) if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

b. Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two (2) months post-partum. The coverage group includes all pregnant women with income up to two hundred fifty-three (253%) of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

c. Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age one (1), children from age one (1) to age nineteen (19) with income up to two hundred sixty-one percent (261%) of the FPL; and qualified and legally present non-citizen infants and children up to the age of nineteen (19), who have income up to two hundred sixty-one percent (261%) of the FPL.

d. Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to one hundred thirty-three percent (133%) of the FPL who meet the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other State plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

15. "Medicaid Code of Administrative Rules" or "MCAR" means the collection of administrative Rules governing the Medicaid program in Rhode Island that is being revised and re-codified as the "Rhode Island Code of Regulations" or "RICR."

16. "Medically needy" means a classification of persons eligible to receive Medicaid based upon similar characteristics who are subject to the MAGI standard for determining income eligibility.

17. “Navigator” means a person working for a State-contracted organization with certified assisters who have expertise in Medicaid eligibility and enrollment.

18. “Non-MAGI coverage group” means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or living with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly-funded program, including children in foster care, anyone receiving Supplemental Security Income (SSI) or eligible for or enrolled in the Medicare Premium Assistance Program.

19. “Peer navigator” means paraprofessionals with specialized training who are community resource specialists employed and supervised by peer advocacy organizations.

20. “Prospective Medicaid enrollee” means a Medicaid beneficiary or family who has not enrolled in an MCO.

21. “Prudent layperson standard” means the standard used to determine the need for an emergency room visit. An “emergency” is defined as a condition that a prudent layperson “who possesses an average knowledge of health and medicine” expects may result in:

    a. Placing a patient in serious jeopardy;

    b. Serious impairment of bodily function; or

    c. Serious dysfunction of any bodily organs.

22. “Rhody health partners” means the Medicaid managed care program that delivers affordable health coverage to eligible adults without dependent children, ages nineteen (19) to sixty-four (64), under § 2.18 of this Part and adults with disabilities eligible under Part 40-10-1 of this Title.

23. “RIte care” means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age nineteen (19), young adults older than age nineteen (19), and foster children (DCYF custody) (see § 2.1 of this Part).

24. “RIte share” means the Medicaid premium assistance program for eligible individuals and families who have access to cost-effective commercial coverage.

25. "Urgent medical problem” means a medical, physical, or mental condition manifesting itself by acute symptoms of sufficient severity (including

severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected to result in:

a. Placing the patient's health in serious jeopardy;

b. Serious impairment to bodily function; or

c. Serious dysfunction of any bodily organ or part.

2.5 Coverage Groups in RIte Care

A. The RIte Care population consists of members of: certain Medicaid affordable care coverage (MACC) groups; coverage groups whose eligibility is NOT based on the MAGI standard (non-MAGI) and several non-Medicaid coverage groups.

1. Medicaid Affordable Care Coverage (MACC) Groups -- RIte Care plans provides coverage for individuals and families in the following MACC groups:

a. Families with income up to one hundred sixteen percent (116 %) of the FPL and parents and caretaker relatives with income between one hundred sixteen percent (116%) and one hundred forty-one percent (141%) of the FPL who have dependent children up to age eighteen (18) or, if attending school full-time, up to age nineteen (19).

b. Pregnant women with family income up to two hundred fifty-three percent (253%) of the FPL, including non-citizen pregnant women.

c. Children up to age nineteen (19) with family income up to two hundred sixty-one percent (261%) of the FPL, including qualified non-citizen children.

2. Non-MAGI MACC Beneficiaries – Rite Care MCOs also provide health services to:

a. Children up to age eighteen (18) or nineteen (19) if completing school who are in foster care and/or receiving adoption subsidy under the applicable provisions of Title IV-E of the Federal Social Security Act (See Medicaid Code of Administrative Rules, Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways (§§ 00-1.7(F)(3) through (4) of this Chapter).

b. Children up to age twenty-one (21) who are Medicaid eligible as result of receiving Supplementary Security Income (SSI). Individuals in the SSI eligible group under age twenty-one (21) who are enrolled in RIte Care managed care may continue enrollment in

a RIte Care MCO when they turn twenty-one (21) years of age until such time as SSI eligibility is discontinued.

c. Young adults aging out of foster care between the ages of eighteen (18) and twenty-six (26). Young adults who were in participating in foster care, kinship, and guardianship programs authorized by the Rhode Island Department of Children, Youth and Families (DCYF) on the date they turned eighteen (18) are eligible, without regard to income, for continued Medicaid coverage until the age of twenty-six (26) under the Foster Care Independence Act of 1999, as amended by the Affordable Care Act of 2010. Members of this population are only eligible in Rhode Island if they were residing in the State at the time they aged out of DCYF foster care. EPSDT services continue only up to age twenty-one (21) for members of this non-MAGI coverage group.

2.6 Excluded Medicaid Coverage Groups

A. There are MACC group beneficiaries who receive coverage on a fee-for-service basis rather than through a RIte Care plan, as follows:

1. Members of these coverage groups who are covered by employer-sponsored or other third (3rd) party health insurance, may receive Medicaid on a fee-for-service basis, rather than through enrollment in a RIte Care MCO:

   a. IV-E foster children and children receiving adoption subsidy (See Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways, § 00-1.7(F)(3) of this Chapter).

   b. SSI recipients under age twenty-one (21) (§ 00-1.5 of this Chapter).

   c. Children with disability – Katie Beckett Eligible. (Part 50-10-3 of this Title). Children under age nineteen (19) who: are living at home; require a hospital, nursing home or ICF-ID level of care; and would qualify for Medicaid if in a licensed health care institution.

   d. SSI recipients over age twenty-one (21).

2. Medically needy populations. Flex-test cases are included in the RIte Care program but receive services in the fee-for-service system. With the exception of Katie Beckett children, long-term care coverage groups (Part 50-00-1 of this Title) do not receive services through a RIte Care MCO.

3. Extended family planning group. Beneficiaries eligible through this pathway in this RIte Care waiver group are entitled to a limited scope of services rather than comprehensive benefits. The group consists of women who meet the following conditions: income must be above the

Medically Needy income limit; if pregnant, income must not exceed two hundred fifty-three percent (253%) of FPL; the women must be sixty (60) days postpartum or sixty (60) days post-loss of pregnancy and, as a result, subject to discontinuation of Medicaid eligibility. Coverage is available for up to twenty-four (24) months.

2.7 Retroactive Coverage

Requests for retroactive eligibility are evaluated at the time of application, but must not delay a decision on prospective eligibility. Retroactive eligibility is not available to MACC groups enrolled in RIte Care. Foster and adoption subsidy children in Non-MAGI coverage groups are eligible for retroactive coverage if eligible for SSI. Retroactive coverage is also available to SSI-related eligible individuals and SSI-related medically needy flex-test cases. If eligibility exists, retroactive payment for services is on a fee-for-service basis and does not exceed a three-month time period.

2.8 Overview of RIte Care Services

A. Individual and families enrolled in RIte Care receive the full scope of services covered under the Medicaid State Plan and the State’s Section 1115 waiver, unless otherwise indicated. Covered services may be provided through the MCO or through the fee-for-service delivery system if the service is “out-of-plan” – that is, not included in the MCO but covered under Medicaid. Fee-for-service benefits may be furnished by any participating provider. Rules of prior authorization apply to any service required by EOHHS. Each RIte Care member selects a primary care provider (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care provider orders treatment determined to be medically necessary in accordance with MCO policies. Beneficiaries in the Extended Family Planning (EFP) coverage group do not require a PCP. The extended family planning group is entitled only to family planning services.

1. Access to Benefits – Unless otherwise specified, members of all RIte Care coverage groups (MACC, Non-MAGI) are entitled to a comprehensive benefit package that includes both in-plan and specific out-of-plan services. Categories of eligibility for the extended family planning benefit package are as follows:

    a. Women otherwise Medicaid ineligible. The package of services is available without the comprehensive benefit package. Women who have given birth and are not eligible for Medicaid under another coverage group lose the full scope of covered services sixty (60) days postpartum or post-loss of pregnancy. Women in this category are eligible for RIte Care for a period of up to twenty-four (24) months for the full family planning benefit package. The benefit

package includes interpreter services but does not include transportation benefits. Renewal is required at twelve (12) months.

b. Women who are otherwise eligible for Medicaid. Women enrolled in RIte Care are eligible for family planning services. Participation is voluntary. Members continue to be enrolled with the same MCO they selected or were assigned to for comprehensive health service delivery but for family planning services only for a twelve (12) month period. Upon renewal at twelve (12) months, a participant may qualify for up to an additional twelve (12) months. Services are covered on an outpatient basis only. Non-prescription contraceptives are covered for members in this category with a provider's order (i.e., prescription).

2. Delivery of Benefits – The coverage provided through RIte Care is categorized as follows:

   a. In-Plan Benefits

   b. Out-of-Plan Benefits.

3. Medical necessity – The standard of "medical necessity" is used as the basis for determining whether access to Medicaid-covered services is required and appropriate. A "medically necessary service" means medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health-related condition including any such services that are necessary to prevent a detrimental change in either medical or mental health status or substance use disorder or services needed to achieve age-appropriate growth and development or to attain, maintain, or regain functional capacity. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

4. Early Periodic Screening, Diagnosis and Treatment (EPSDT) -- The EPSDT provision in Title XIX mandates that state Medicaid programs must provide coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct defects and physical and mental illnesses and conditions discovered through screening or at any other occasion, whether or not those services are covered by the State Medicaid Plan or the State's Medicaid Section 1115 waiver. This applies to members of the MACC group up to age nineteen (19), SSI-eligible children and young adults up to age twenty-one (21), including adults aging out of foster care up to age twenty-one (21). A young adult over age nineteen (19) who transitions from the MACC group for children and young adults to the MACC group for adults from age nineteen (19) to sixty-four (64) also receives EPSDT services until age twenty-one (21).

2.9 RIte Care In-Plan Capitated Benefits

A. The benefits which the MCO provides or arranges within the capitated (fixed cost per enrollee per month) benefit are set forth below.

B. In-Plan benefits subject to the capitated rate are organized as follows: the RIte Care comprehensive benefit package and the extended family planning benefit package. Adults who are found to be severely and persistently mentally ill have access to a comprehensive benefit package. All elements of the comprehensive benefit package are the responsibility of the MCO when beneficiaries in this group receive coverage through the RIte Care managed care delivery system.

C. RIte Care comprehensive benefit package --The following benefits are included in the capitated rate on an annual basis, based on medical necessity:

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Inpatient Hospital Care	As medically necessary. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in an MCO. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's MCO and enrolled in another MCO or re-enrolled into Medicaid fee-for-service, until the management of the Member's care is formally transferred to the care of another MCO, another program option, or fee-for-service Medicaid.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting.
Therapies	Covered as medically necessary, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Physician/Provider Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care.
Family Planning Services	Enrolled female members have freedom of choice of providers for family planning services.
Prescription Drugs	Covered when prescribed by an MCO physician/provider. Generic substitution only unless provided for otherwise as described in the Managed Care Pharmacy Benefit Plan Protocols.
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the Medicaid Managed Care Pharmacy Benefit Plan Protocols. Includes nicotine cessation supplies ordered by an MCO physician. Includes medically necessary nutritional supplements ordered by an MCO physician.
Laboratory Services	Covered when ordered by an MCO physician/provider including urine drug screens.
Radiology Services	Covered when ordered by an MCO physician/provider.
Diagnostic Services	Covered when ordered by an MCO physician/provider.
Mental Health and Substance Use –Outpatient& Inpatient	Covered as needed for all members, including residential substance use treatment for youth. Covered services include a full continuum of mental health and substance use disorder treatment, including but not limited to, community-based narcotic treatment, methadone, and community detox. Covered residential treatment includes therapeutic

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days, or hospital-based detox, MH/SUD residential treatment (including minimum six (6) month SSTAR birth residential services), Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST),Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs.
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician/provider/APP including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home health services do not include respite care, relief care or day care.
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician/provider including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.
Preventive Services	Covered when ordered by a health plan physician/provider. Services include homemaker services, minor environmental modifications, physical therapy evaluation and services, and personal care services.
EPSDT Services	Provided to all children and young adults up to age twenty-one (21). Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as medically indicated. Includes multi-disciplinary evaluations and treatment, including, PT/OT/ST, for children with significant disabilities or developmental delays.
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services or when authorized by an MCO Provider, or in order to assess whether a condition warrants treatment as an emergency service.
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by an MCO physician/provider. For Rhody Health Partners/Expansion members, the Contractor payments are limited to thirty (30) consecutive days. All skilled and custodial care covered. Contractor is responsible for notifying the State

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	to begin disenrollment process. For RIte Care members, please refer to stop-loss provisions.
School-Based Clinic Services	Covered for RIte Care members as Medically Necessary at all designate sites.
Services of Other Practitioners	Covered if referred by an MCO physician or APP. Practitioners certified and licensed by the State of Rhode Island including social workers, licensed dietitians, psychologists and licensed nurse midwives.
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body, such as a Probation Officer, the Rhode Island State Parole Board. If the length of stay is not prescribed on the court order, the MCOs may conduct Utilization Review on the length of stay. The MCOs must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. Condition of Probation: Treatment is prescribed as a condition of probation Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.).

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.
Court-ordered mental health and substance use treatment – civil court	All Civil Mental Health Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the R.I. Gen. Laws § 40.1-5-5 must be followed. If the length of stay is not prescribed on the court order, the MCOs may conduct Utilization Review on the length of stay. The MCOs must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Note the following are facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than seven (7) calendar days, will be disenrolled from the Health Plan at the end of the month, and be re-assigned into Medicaid FFS. Civil Court Ordered Treatment can be from the result of: Voluntary Admission Emergency Certification Civil Court Certification Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. Court ordered treatment is exempt from the fourteen (14) day prior authorization requirement for residential treatment.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Podiatry Services	Covered as ordered by an MCO physician/provider.
Optometry Services	For children under twenty-one (21): Covered as medically necessary with no other limits. For adults twenty-one (21) and older: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in two (2) years only if medically necessary. Eyeglass frames are covered only every two (2) years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.
Oral Health	Inpatient: Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. Outpatient: Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. Oral Surgery: Treatment covered as medically necessary. As detailed in the Schedule of In-Plan Oral Health Benefits updated January 2017.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Hospice Services	Covered as ordered by an MCO physician/provider. Services limited to those covered by Medicare.
Durable Medical Equipment	Covered as ordered by an MCO physician/provider as medically necessary.
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.
Children's Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.
Nutrition Services	Covered as delivered by a registered or licensed dietitian for certain medical conditions and as referred by an MCO physician or APP.
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.
Interpreter Services	Covered as needed.
Transplant Services	Covered when ordered by an MCO physician.
HIV/AIDS **Non-Medical Targeted Case Management for People**	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV (see provider manual for distinct

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring Risk for Acquiring HIV	eligibility criteria for beneficiaries to qualify for this service). These services provide a series of consistent and required “steps” such that all clients are provided with and Intake, Assessment, Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid’s state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the State. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible All types of case management encounters and communications (face-to-face, telephone contact, other) Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. A series of metrics and quality performance measures for both HIV case management for PLWH/s and those at high risk for HIV will be

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	collected by providers and are required outcomes for delivering this service. Does not involve coordination and follow up of medical treatments.
AIDS Medical Case Management	Medical Case Management services (including treatment adherence) are a range of client - centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the beneficiary's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIVIAIDS treatments. Key activities include 1) Initial assessment of service needs; 2) Development of a comprehensive, individualized service plan; 3) Coordination of services required to implement the plan; 4) Monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time beneficiary is enrolled in services. It includes beneficiary-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other form of communication.
Treatment for Gender Dysphoria	Comprehensive benefit package.
Early Intervention	Covered for RIte Care members as included within the Individual Family Service Plan (IFSP),

SERVICE	SCOPE OF BENEFIT (ANNUAL) **Including but not limited to:**
	consistent with the 2005 Article 22 of the General Laws of Rhode Island Subject to stop loss greater than five thousand dollars ($5,000.00).
Rehabilitation Services	Physical, occupational and speech therapy services may be provided with physician orders by Rhode Island Department of Health-licensed outpatient rehabilitation centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider. See also EPSDT.
In Lieu of Service	All services as provided in § 2.9(C) of this Part can be utilized as an in Lieu of Service if alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting.
Value Add Services	Services/equipment which are not in the State Plan but are cost effective, improve health and clinically appropriate.
Neonatal Intensive Care Unit (NICU)	Covered under the following circumstances: Admitted to Women and Infants (W&I) from home after discharge, admitted to W&I NICU from home after discharge from W&I Normal Newborn Nursery, Admission to non-W&I level 2 Nursery, Admission to W&I NICU from home following delivery at and discharge from non-W&I facility or discharge from non-W&I NICU with admission to W&I for continued care.

D. Extended family planning services – The extended family planning group benefit package includes:

1. Gynecological Services. Limited to no more than four (4) office visits annually – One (1) comprehensive gynecological annual exam and up to three (3) additional family planning method related office visits if indicated.

2. Laboratory. Includes annual Pap smear; STD screening if indicated; anemia testing; dipstick urinalysis and urine culture if indicated; pregnancy testing.

3. Procedures. Limited to the following office/clinic/outpatient procedures if indicated tubal ligation; treatment for genital warts; Norplant insertion and removal; IUD insertion and removal; incision and drainage of a Bartholin's gland cyst or abscess.

4. Includes generic-first prescriptions and non-prescription family planning methods (Limited to twelve (12) thirty (30) day supplies per year) when prescribed by a health plan physician or APP.

5. Contraceptives. Includes oral contraceptives, contraceptive patch, contraceptive vaginal, contraceptive implant, contraceptive IUD, contraceptive injection, cervical cap, diaphragm, and emergency contraceptive pills, when prescribed by a health care physician. Covered non-prescription methods include foam, condoms, spermicidal cream/jelly, and sponges.

6. Referrals for other medically necessary services as appropriate/indicated, including: referral to State STD clinic for treatment if indicated.

7. Referral to State confidential HIV testing and counseling sites, if indicated.

8. Inpatient services are not a covered benefit, except as medically necessary follow-up treatment of a complication from provision of a covered procedure or service.

9. Categories of eligibility for this extended family planning benefit package are as follows:

    a. Women otherwise Medicaid ineligible. The package of services is available without the comprehensive benefit package. Women who have given birth and are not eligible for Medicaid under another coverage group, lose the full scope of covered services sixty (60) days postpartum or post-loss of pregnancy. Women in this category are eligible for RIte Care for a period of up to twenty-four (24) months for the full family planning benefit package. The benefit package includes interpreter services but does not include transportation benefits. Re-certification is required at twelve (12) months.

b. Women who are otherwise eligible for Medicaid. Women enrolled in RIte Care are eligible for family planning services. Participation is voluntary. Members continue to be enrolled with the same health plan they selected or were assigned to for comprehensive health service delivery but for family planning services only for a twelve (12) month period. Upon re-certification at twelve (12) months, a participant may qualify for up to an additional twelve (12) months. Services are covered on an outpatient basis only. Non-prescription contraceptives are not covered for members in this category.

E. EOHHS policy affects the access to and/or the scope and amount of several benefits as follows:

1. Prescriptions: Generic Policy. For RIte Care enrolled members, prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by EOHHS, or the MCO acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below:

a. Availability of suitable within-class generic substitutes or out-of-class alternatives.

b. Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.

c. Relative disruptions in care that may be brought on by changing treatment from one drug to another.

d. Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.

e. Relative clinical advantages and disadvantages of drugs within a therapeutic class.

f. Cost differentials between brand and generic alternatives.

g. Drugs that are required under Federal and State Regulations.

h. Demonstrated medical necessity and lack of efficacy on a case by case basis.

2. Non-emergency transportation (NEMT) policy. Responsibility for transportation services rests first with the member. If the member's condition, place of residence, or the location of medical provider does not permit the use of bus transportation, NEMT for the Medicaid enrollee may be arranged for by EOHHS or its agent for transportation to a Medicaid-covered service from a Medicaid-participating provider. NEMT service

includes bus passes, and other RIPTA fare products, if authorized by EOHHS or its agent.

3. Interpretation services policy. EOHHS will notify the health plan when it knows of members who do not speak English as a first language who have either selected or been assigned to the plan. If the health plan has more than fifty (50) members who speak a single language, it must make available general written materials, such as its member handbook, in that language.

   a. Written material must be available in alternative formats, such as audio and large print, and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services. All enrollees must be informed that information is available in alternative formats and how to access those formats.

4. Tracking, Follow-up, Outreach. These services are provided by the MCO in association with an initial visit with member's PCP; for preventive visits and prenatal visits; referrals that result from preventive visits; and for preventive dental visits. Outreach includes mail, phone, and home outreach, if necessary, for members who miss preventive and follow-up visits, and to resolve barriers to care such as language and transportation barriers.

2.10 Out-of-Plan Benefits

A. Out-of-plan benefits are not included in the capitated rate paid to the MCOs and are not the responsibility of the MCO to provide. These services are provided by existing Medicaid-approved providers who are reimbursed directly by EOHHS on a fee-for-service basis. Out-of-plan benefits are provided to all Rite Care enrollees with the following exceptions: Individuals eligible for Extended Family Planning only; Pregnant women who are otherwise ineligible for Medicaid and post-partum women with income above two hundred fifty-three percent (253%) of FPL; and anyone enrolled in the guaranteed enrollment period but otherwise ineligible for Medicaid. The covered benefits are as follows:

ELIGIBLE GROUP	BENEFIT(S) PROVIDED OUT-OF-PLAN
All Rhody Health Partners, RIte Care and Expansion members	Dental services Court-ordered mental health and substance use services ordered to a non- network facility or provider Non-Emergency Transportation Services (Non-Emergency transportation is coordinated by the contracted Health Plans). Nursing home services in excess of thirty (30) consecutive days (RHP members only) Residential services for MR/DD clients that are paid by the State's BHDDH Respite (Adult) Neonatal intensive care Unit (NICU) Services at Women's and Infants Hospital. Except as specified in § 2.9(C) of this Part Special Education services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays Lead Program home assessment and non-medical case management provided by Department of Health or Lead Centers for lead poisoned children Cedar Family Center Services Centers of Excellence Programs

2.11 Limits on Services

A. The following services are not covered under the RIte Care program:

1. Experimental procedures, except as required by Rhode Island State law;

2. Abortion services, except to preserve the life of the woman, or in cases of rape or incest;

3. Private rooms in hospitals (unless medically necessary);

4. Cosmetic surgery;

5. Medications that treat erectile dysfunction or other sexual disorders;

6. Infertility treatment services; and

7. Any portion of services that exceeds fifteen (15) days provided in an Institution for Mental Diseases (IMD) for individuals between the ages of twenty-one (21) to sixty-four (64).

B. Out-of-State Coverage

Out-of-State Benefits — EOHHS does not routinely provide coverage for out-of-State services with certain exceptions: Medicaid services provided in border communities are covered and emergency services are covered, within limits, at the discretion of EOHHS or the MCO.

2.12 Scope of Provider Networks

The MCO must maintain provider networks in locations that are geographically accessible to the populations to be served, comprised of hospitals, physicians, advanced practice practitioners, mental health providers, substance use disorder providers, pharmacies, transportation services, dentists, school based health centers, etc. in sufficient numbers to make available all services in a timely manner.

2.13 Mainstreaming/Selective Contracting

A. The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of the Medicaid program. The MCO must ensure that all of its network providers accept RIte Care members for treatment. The MCO also must accept responsibility for ensuring that network providers do not intentionally segregate RIte Care members in any way from other persons receiving services.

B. Health plans may develop selective contracting arrangements with certain providers for the purpose of cost containment, but must still adhere to the access standards as defined in the health plan contracts.

2.14 Primary Care Providers (PCPs)

A. The MCO has written policies and procedures allowing every member to select a primary care provider (PCP). If a member does not select a PCP during enrollment, the MCO shall make an automatic assignment, taking into consideration such factors as current provider relationships, language needs, and the relative proximity of the PCP to the member’s area of residence. The

health plan must notify the member in a timely manner of his/her PCP's name, location, and office telephone number, and how to change PCPs, if desired. The PCP serves as the member's initial and most important point of interaction with the MCO network. In addition to performing primary care services, the PCP coordinates referrals and specialty care. As such, PCP responsibilities include at a minimum:

1. Serving as the member's primary care provider;

2. Ensuring that members receive all recommended preventive and screening care appropriate for their age group and risk factors;

3. Referring for specialty care and other medically necessary services both in and out-of-plan;

4. Maintaining a current medical record for the member; and

5. Adhering to the EPSDT periodicity schedule for members under age twenty-one (21).

B. In addition, the MCO retains responsibility for monitoring PCP actions to ensure they comply with health plan and Medicaid program policies.

2.15 Service Accessibility Standards

A. The service accessibility standards which the health plan must meet are:

1. Twenty-four (24) hour coverage;

2. Travel time or distance;

3. Days to appointment for non-emergency services.

B. In addition, MCOs must staff both a member services and a provider services function.

1. Twenty-Four Hour Coverage – The MCO must provide coverage, either directly or through its PCPs, to members on a twenty-four (24) hours per day, seven (7) days a week basis. The MCO must also have available written policy and procedures describing how members and providers can contact it to receive instruction or prior authorization for treatment of an emergent or urgent medical problem.

2. Travel Time – The MCO must make available to every member a PCP whose office is located within twenty (20) minutes or twenty (20) miles driving time from the member's place of residence. Members may, at their discretion, select PCPs located farther from their homes.

3. Appointment for Non-Emergency Services – The MCO must make services available within twenty-four (24) hours and seven (7) days per week, including services for mental health and substance use disorders for treatment of an urgent medical problem. The MCO must make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days. Non-emergent, non-urgent mental health or substance use appointments for diagnosis and treatment must be made available within ten (10) days.

4. Member Services – The MCO must staff a member services function operated at least during regular business hours and responsible for the following:

   a. Orienting the member to the health plan and assisting members in the selection of a PCP;

   b. Assisting members to make appointments and obtain services;

   c. Assisting in arranging medically necessary transportation for members;

   d. Arranging interpreter services;

   e. Assisting in reporting fraud, waste, and abuse;

   f. Assisting members with coordination of out-of-plan services;

   g. Ordering member materials, such as handbooks and provider directories;

   h. Explaining to members what to do in an emergency or urgent medical situation;

   i. Assisting members with questions regarding benefits and how to access services;

   j. Handling members' complaints, grievances, and appeals; and

   k. Providing a toll-free telephone number.

C. The MCO must maintain a toll-free Member Services telephone number. Although the full Member Services function is not required to operate after regular business hours, this or another toll-free telephone number must be staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and weekends, including pharmacy services.

D. Provider Services – The MCO must staff a provider Services function operated at least during regular business hours and responsible for the following:

1. Assisting providers with questions concerning member eligibility status and benefits;

2. Assisting providers with plan prior authorization, care coordination, network questions, and referral procedures;

3. Assisting providers with claims payment procedures;

4. Handling provider complaints.

2.16 Mandatory Participation in Managed Care

Participation in managed care is mandatory for the members of the MACC, non-MAGI and non-Medicaid funded coverage groups identified in § 2.1 of this Part except as specified in § 2.34 of this Part. Medicaid members in these coverage groups with third (3rd) party medical coverage or insurance may be exempt from this mandate only as indicated in § 2.38 of this Part at the discretion of the EOHHS.

2.17 Enrollment Procedures, Rights and Responsibilities

The enrollment process for MACC groups is set forth in § 2.34 of this Part.

2.18 Rhody Health Partners – Program Overview

A. Rhody Health Partners (RHP) is a managed care delivery system for adult Medicaid beneficiaries ages nineteen (19) to sixty-four (64) eligible under the ACA expansion as well as adults with disabilities eligible under Part 40-00-1 of this Title.

B. As with RIte Care, beneficiaries under this Rule who have access to a Medicaid approved employer-sponsored health insurance plans are evaluated for participation in the RIte Share Premium Assistance Program and are required to enroll in an employer plan approved by EOHHS as a condition of retaining Medicaid eligibility.

2.19 Scope and Purpose

Eligible members of the MACC group for adults ages nineteen (19) to sixty-four (64) and must not be eligible for or enrolled in Medicare will be enrolled in a RHP health plan or, as applicable, RIte Share. The purpose of this section is to describe the RHP delivery system for members of this MACC coverage group and the respective roles and responsibilities of EOHHS and the individuals receiving affordable coverage through RHP.

2.20 Applicability

The provisions governing RHP for persons who are eligible for Medicaid on the basis of being aged, blind, or with a disability are located in Part 40-10-1 of this Title.

2.21 MACC Group in Rhody Health Partners

The MACC group participating in RHP is adults, ages nineteen (19) to sixty-four (64), who are not: pregnant, entitled to received Medicare Part A or B, or otherwise eligible for or enrolled in a Medicaid State Plan mandatory coverage group. See: Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways (Subchapter 00 Part 1 of this Chapter).

2.22 Overview of RHP

Individuals enrolled in RHP receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver, unless otherwise indicated. Covered services may be provided through the MCO or through the fee-for-service delivery system if the service is "out-of-plan" – that is, not included in the MCO but covered under Medicaid. Fee-for-service benefits may be furnished either by the managed care provider or by any participating provider. Rules of prior authorization apply to any service required by EOHHS. In response to the novel Coronavirus Disease (COVID-19), EOHHS will temporarily suspend most prior authorization requirements. Effective October 1, 2021, prior authorization requirements will be reinstated for all services except for behavioral healthcare services. Effective January 1, 2022, prior authorizations will be reinstated for behavioral healthcare services. Each RHP member selects a primary care provider (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care provider orders treatment determined to be medically necessary in accordance with MCO policies.

2.23 Access to Benefits

A. Unless otherwise specified, MACC group adults coverage groups entitled to a comprehensive benefit package that includes both in-plan and out-of-plan services. In-plan services are paid for on a capitated basis. The State may, at its discretion, identify other services paid for on a fee-for-service basis rather than at a capitated rate.

B. Delivery of Benefits – The coverage provided through the RHP is categorized as follows:

   1. In-Plan Benefits

   2. Out-of-Plan Benefits

C. Medical necessity – The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered services is required and appropriate. A "medically necessary service" means medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health-related condition including any such services are necessary to prevent a decremental change in either medical or mental health status or substance use disorder or services needed to achieve age-appropriate growth and development or to attain, maintain, or regain functional capacity.

D. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

2.24 RHP In-Plan Capitated Benefits

A. The benefits which the MCO provides within the capitated (fixed cost per enrollee per month) benefit.

B. RHP comprehensive benefit package – The following benefits are included in the capitated rate on an annual basis, based on medical necessity:

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Inpatient Hospital Care	As medically necessary. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from Contractor's Health Plan and enrolled in another MCO or re-enrolled into Medicaid fee-for-service, until the management of the Member's care is formally transferred to the care of another MCO, another program option, or fee-for-service Medicaid.
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting.
Therapies	Covered as medically necessary, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Physician/Provider Services	Covered as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care.
Family Planning Services	Enrolled female members have freedom of choice of providers for family planning services.
Prescription Drugs	Covered when prescribed by an MCO physician/provider. Generic substitution only unless provided for otherwise as described in the Managed Care Pharmacy Benefit Plan Protocols.
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider/APP. Limited to non-prescription drugs, as described in the Medicaid Managed Care Pharmacy Benefit Plan Protocols. Includes nicotine cessation supplies ordered by an MCO physician or APP. Includes medically necessary nutritional supplements ordered by an MCO physician or APP.
Laboratory Services	Covered when ordered by a Health Plan physician/provider including urine drug screens.
Radiology Services	Covered when ordered by a Health Plan physician/provider.
Diagnostic Services	Covered when ordered by a Health Plan physician/provider.
Mental Health and Substance Use – Outpatient & Inpatient	Covered as needed for all members, including residential substance use treatment for youth. Covered services include a full continuum of mental health and substance use disorder treatment, including but not limited to, community-based narcotic treatment, methadone, and community detox. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days, or hospital-based detox, MH/SUD residential treatment (including minimum six (6) month SSTAR birth residential services), Mental Health Psychiatric Rehabilitative Residence

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	(MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST),Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs.
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician/provider including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by an MCO physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home health services do not include respite care, relief care or day care.
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician/provider including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.
Preventive Services	Covered when ordered by a health plan physician/provider. Services include homemaker services, minor environmental modifications, physical therapy evaluation and services, and personal care services.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
EPSDT Services	Provided to all children and young adults up to age twenty-one (21). Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as medically indicated. Includes multi-disciplinary evaluations and treatment, including, PT/OT/ST, for children with significant disabilities or developmental delays.
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services or when authorized by an MCO Provider, or in order to assess whether a condition warrants treatment as an emergency service.
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician/provider. For Rhody Health Partners/Expansion members, the Contractor payments are limited to thirty (30) consecutive days. Please refer to the Nursing Home Status Form Policy. All skilled and custodial care covered. Contractor is responsible for notifying the State to begin dis-enrollment process. For RIte Care members, please refer to stop-loss provisions.
School-Based Clinic Services	Covered for RIte Care members as Medically Necessary at all designate sites.
Services of Other Practitioners	Covered if referred by an MCO physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body, such as a Probation Officer, the Rhode Island State Parole Board. If the length of stay is not prescribed on the court order, the MCOs may conduct Utilization Review on the length of stay. The MCOs must offer appropriate transitional care management to persons upon discharge

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. Condition of Probation: Treatment is prescribed as a condition of probation. Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.
Court-ordered mental health and substance use treatment – civil court	All Civil Mental Health Court Ordered Treatment must be provided in totality as an in-plan benefit. All Regulations in the R.I. Gen. Laws § 40.1-5-5 must be followed. If the length of stay is not prescribed on the court order, the MCOs may conduct Utilization Review on the length of stay. The MCOs must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Note the following are facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than seven (7) calendar days, will be dis-enrolled from the MCO at the end of the month, and be re-assigned into Medicaid FFS. Civil Court Ordered Treatment can be from the result of:

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. Court ordered treatment is exempt from the fourteen (14) day prior authorization requirement for residential treatment.
Podiatry Services	Covered as ordered by Health Plan physician/provider.
Optometry Services	For children under twenty-one (21): Covered as medically necessary with no other limits. For adults twenty-one (21) and older: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two (2) years. Eyeglass lenses are covered more than once in two (2) years only if medically necessary. Eyeglass frames are covered only every two (2) years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.
Oral Health	Inpatient: Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. Outpatient: Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	Oral Surgery: Treatment covered as medically necessary. As detailed in the Schedule of In-Plan Oral Health Benefits updated January 2017.
Hospice Services	Covered as ordered by an MCO physician/provider. Services limited to those covered by Medicare.
Durable Medical Equipment	Covered as ordered by an MCO physician/provider as medically necessary.
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.
Children's Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.
Nutrition Services	Covered as delivered by a registered or licensed dietitian for certain medical conditions and as referred by an MCO physician.
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.
Interpreter Services	Covered as needed.
Transplant Services	Covered when ordered by an MCO physician.
HIV/AIDS	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV (see

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	provider manual for distinct eligibility criteria for beneficiaries to qualify for this service). These services provide a series of consistent and required "steps" such that all clients are provided with and Intake, Assessment, Care Plan. All providers must utilize an acuity index to monitor beneficiary severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals, such as HIV/AIDS, by age or health/mental health condition, or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: Benefits/entitlement counseling and referral activities to assist eligible beneficiaries to obtain access to public and private programs for which they may be eligible All types of case management encounters and communications (face-to-face, telephone contact, other) Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. A series of metrics and quality performance measures for both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Does not involve coordination and follow up of medical treatments.
AIDS Medical Case Management	Medical Case Management services (including treatment adherence) are a range of beneficiary-centered services that link beneficiaries with health care, psychosocial, and other services. The coordination and follow-up of medical

SERVICE	SCOPE OF BENEFIT (ANNUAL) **Including but not limited to:**
	treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIVIAIDS treatments. Key activities include 1) Initial assessment of service needs; 2) Development of a comprehensive, individualized service plan; 3) Coordination of services required to implement the plan; 4) Monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time beneficiary is enrolled in services. It includes beneficiary-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other form of communication.
Treatment for Gender Dysphoria	Comprehensive benefit package.
Rehabilitation Services	Physical, Occupational and Speech therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider. See also EPSDT.
In Lieu of Service	All services as provided in § 2.9(C) of this Part can be utilized as an in Lieu of Service if alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting.
Value Add Services	Services/equipment which are not in the State Plan but are cost effective, improve health and clinically appropriate.

C. EOHHS policy affects the access to and/or the scope and amount of several benefits as follows:

1. Prescriptions: Generic Policy. For RHP enrolled members, prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by EOHHS, or the MCO acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below:

    a. Availability of suitable within-class generic substitutes or out-of-class alternatives.

    b. Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.

    c. Relative disruptions in care that may be brought on by changing treatment from one drug to another.

    d. Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.

    e. Relative clinical advantages and disadvantages of drugs within a therapeutic class.

    f. Cost differentials between brand and generic alternatives.

    g. Drugs that are required under Federal and State Regulations.

    h. Demonstrated medical necessity and lack of efficacy on a case by case basis.

2. Non-emergency medical transportation (NEMT) policy. Responsibility for transportation services rests first with the member. If the member's condition, place of residence, or the location of medical provider does not permit the use of bus transportation, NEMT for the Medicaid enrollee may be arranged for by EOHHS or its agent for transportation to a Medicaid covered service from a Medicaid participating provider, including medical, dental, and behavioral health care services. NEMT services include bus passes, other RIPTA fare products, if authorized by EOHHS or its agent.

3. Interpretation services policy. EOHHS will notify the MCO when it knows of members who do not speak English as a first (1st) language who have either selected or been assigned to the MCO. If the MCO has more than fifty (50) members who speak a single language, it must make available general written materials, such as its member handbook, in that language.

    a. Written material must be available in alternative formats, such as audio and large print, and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. All written materials for potential enrollees must include taglines in the prevalent non-English

languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services. All enrollees must be informed that information is available in alternative formats and how to access those formats.

4. Tracking, Follow-up, Outreach. These services are provided by the MCO in association with an initial visit with member's PCP; for preventive visits and prenatal visits; referrals that result from preventive visits; and for preventive dental visits. Outreach includes mail, phone, and home outreach, if necessary, for members who miss preventive and follow-up visits, and to resolve barriers to care such as language and transportation barriers.

2.25 SPMI Modifications

SPMI adults have access to a comprehensive benefit package. All elements of the comprehensive benefit package are the responsibility of the MCO when a beneficiary is enrolled in the Rhody Health Partners delivery system.

2.26 Out-of-Plan Benefits

A. Out-of-plan benefits are not included in the managed care contracts and are not the responsibility of the MCO to provide. These services are provided by existing Medicaid-approved providers who are reimbursed directly by EOHHS on a fee-for-service basis. Out-of-plan benefits are provided to all RHP enrollees with the following exceptions: anyone enrolled in the guaranteed enrollment period but otherwise ineligible for Medicaid. The covered benefits are as follows:

ELIGIBLE GROUP	BENEFIT(S) PROVIDED OUT-OF-PLAN
All Rhody Health Partners and Expansion members	Dental services Court-ordered mental health and substance use services ordered to a non- network facility or provider Non-Emergency Transportation Services (Non-Emergency transportation is coordinated by the contracted Health Plans) Nursing home services in excess of thirty (30) consecutive days Residential services for MR/DD clients that are paid by the State's BHDDH Respite (Adult) Neonatal intensive care Unit (NICU) Services at Women's and Infants Hospital. Except as specified in § 2.9(C) of this Part Special Education services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays Lead Program home assessment and non-medical case management provided by Department of Health or Lead Centers for lead poisoned children Cedar Family Center Services (RIte Care) Centers of Excellence Programs

2.27 Services that are Not Covered by Medicaid

A. Non-covered services – The following services are not covered under the Medicaid program:

1. Experimental procedures, except as required by Rhode Island State law;

2. Abortion services, except to preserve the life of the woman, or in cases of rape or incest;

3. Private rooms in hospitals (unless medically necessary);

4. Cosmetic surgery;

5. Medications that treat erectile dysfunction or other sexual disorders;

6. Infertility treatment services; and

7. Any portion of services that exceeds fifteen (15) days provided in an Institution for Mental Diseases (IMD) for individuals between the ages of twenty-one (21) to sixty-four (64). RHP managed care enrollees may access IMDs.

B. Out-of-State Coverage – EOHHS does not routinely provide coverage for out-of-State services with certain exceptions: Medicaid services provided in border communities are covered and emergency services are covered, within limits, at the discretion of EOHHS or the managed care organization.

2.28 Scope of Provider Networks

The MCO must maintain provider networks in locations that are geographically accessible to the populations to be served, comprised of hospitals, physicians, advanced practice practitioners, mental health providers, substance use disorder providers, pharmacies, transportation services, dentists, school based health centers, etc. in sufficient numbers to make available all services in a timely manner.

2.29 Mainstreaming/Selective Contracting

A. The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of EOHHS. The MCO must ensure that all of its network providers accept RHP members for treatment. The MCO also must accept responsibility for ensuring that network providers do not intentionally segregate RHP members in any way from other persons receiving services.

B. Health plans may develop selective contracting arrangements with certain providers for the purpose of cost containment, but must still adhere to the access standards as defined in the health plan contracts.

2.30 Primary Care Providers (PCPs)

A. The MCO has written policies and procedures allowing every member to select a primary care provider (PCP). If a member does not select a PCP during enrollment, the MCO shall make an automatic assignment, taking into consideration such factors as current provider relationships, language needs, and the relative proximity of the PCP to the member's area of residence. The MCO must notify the member in a timely manner of his/her PCP's name, location, and office telephone number, and how to change PCPs, if desired. The

PCP serves as the member's initial and most important point of interaction with the health plan network. In addition to performing primary care services, the PCP coordinates referrals and specialty care. As such, PCP responsibilities include at a minimum:

1. Serving as the member's primary care provider;

2. Ensuring that members receive all recommended preventive and screening care appropriate for their age group and risk factors;

3. Referring for specialty care and other medically necessary services both in and out-of-plan;

4. Maintaining a current medical record for the member; and

B. In addition, the MCO retains responsibility for monitoring PCP actions to ensure they comply with health plan and Medicaid program policies.

2.31 Service Accessibility Standards

A. The service accessibility standards which the MCO must meet are:

1. Twenty-four (24) hour coverage;

2. Travel time or distance;

3. Days to appointment for non-emergency services.

B. In addition, MCOs must staff both a member services and provider services function.

1. Twenty-Four Hour Coverage – The MCO must provide coverage, either directly or through its PCPs, to members on a twenty-four (24) hour per day, seven (7) days a week basis. The MCO must also have available written policy and procedures describing how members and providers can contact it to receive instruction or prior authorization for treatment of an emergent or urgent medical problem.

2. Travel Time – The MCO must make available to every member a PCP whose office is located within twenty (20) minutes or twenty (20) miles driving time from the member's place of residence. Members may, at their discretion, select PCPs located farther from their homes.

3. Appointment for Non-Emergency Services – The MCO must make services available within twenty-four (24) hours and seven (7) days per week, including services for mental health and substance use disorders for treatment of an urgent medical problem. The MCO must make services available within thirty (30) days for treatment of a non-emergent, non-

urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days. Non-emergent, non-urgent mental health or substance use disorder appointments for diagnosis and treatment must be made available within ten (10) days.

4. Member Services – The MCO must staff a member services function operated at least during regular business hours and responsible for the following:

   a. Orienting the member to the health plan and assisting members in the selection of a PCP;

   b. Assisting members to make appointments and obtain services;

   c. Assisting in arranging medically necessary transportation for members;

   d. Arranging interpreter services;

   e. Assisting in reporting fraud, waste, and abuse;

   f. Assisting members with coordination of out-of-plan services;

   g. Ordering member materials, such as handbooks and provider directories;

   h. Explaining to members what to do in an emergency or urgent medical situation;

   i. Assisting members with questions regarding benefits and how to access services;

   j. Handling members' complaints, grievances, and appeals; and

   k. Providing a toll-free telephone number.

5. The MCO must maintain a toll-free member services telephone number. Although the full Member Services function is not required to operate after regular business hours, this or another toll-free telephone number must be staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and weekends, including pharmacy services.

6. Provider Services – The MCO must staff a provider services function operated at least during regular business hours and responsible for the following:

a. Assisting providers with questions concerning member eligibility status and benefits;

b. Assisting providers with plan prior authorization, care coordination, network questions, and referral procedures;

c. Assisting providers with claims payment procedures; and

d. Handling provider complaints.

2.32 Mandatory Participation in Managed Care

Participation in managed care is mandatory for the members of the MACC, non-MAGI and non-Medicaid funded coverage groups identified in § 2.1 of this Part except as specified in § 2.34 of this Part. Medicaid members in these coverage groups with third-party medical coverage or insurance may be exempt from this mandate only as indicated in § 2.38 of this Part, at the discretion of the EOHHS.

2.33 Enrollment Procedures, Rights, and Responsibilities

The enrollment process for MACC groups using the RHP delivery system is set forth in § 2.34 of this Part.

2.34 Enrollment Processes for RIte Care and Rhody Health Partners Managed Care Plans Overview

With the approval of the State’s Title XIX, Section 1115 waiver in 2009, enrollment in an MCO became mandatory for all individuals and families covered in the Rhode Island Medicaid program who do not require long term services and supports. The State’s goal in implementing this policy is to assure that all Rhode Islanders enrolled in Medicaid have access to an organized system of high quality services that provides a medical home focusing on primary care and prevention services.

2.35 Scope and Purpose

A. The Medicaid eligible Medicaid Affordable Care Coverage (MACC) groups identified in the “Affordable Care Coverage Groups” (Subchapter 00 Part 1 of this Chapter) must enroll for coverage in a RIte Care (families, parent/caretaker, children and pregnant women) or Rhody Health Partners (adults nineteen (19) to sixty-four (64) without children) managed care plan, as described above. There are other Medicaid coverage groups enrolled in both service delivery systems.

B. This Rule applies to all RIte Care coverage groups identified in § 2.1 of this Part. It does not apply to adults eligible on the basis of age, blindness, or disability subject to the provisions for RIte Care unless the beneficiary qualifies for and

chooses the eligibility pathway for parents/caretakers. See Part 40-10-1 of this Title for a description of these groups.

C. EOHHS must ensure that enrollment in RIte Care and Rhody Health Partner (RHP) MCOs function in a timely and efficient manner that respects the rights of Medicaid eligible individuals and families and the State's interest in assuring that they have ready access to an organized system of high quality health care.

D. The provisions of this rule also apply to any applicants in these coverage groups who have access to employer-sponsored (ESI) health plans who may be qualified for the RIte Share premium assistance program, as specific in the Medicaid Code of Administrative Rule "RIte Share Premium Assistance Program (Part 3 of this Subchapter), until further notice from the EOHHS.

2.36 Initiating Enrollment: No Wrong Door

A. The enrollment process begins at the point in which an eligibility determination has been made and the applicant is notified. Once determined eligible, a Medicaid member must select an MCO at the time a determination is made if applying online through the web-portal either alone or with assistance. Notice of eligibility provided by EOHHS, whether electronically or on paper, must inform the Medicaid member of whether enrollment in a RIte Care versus Rhody Health Partners plan is required. The Medicaid coverage group that is the basis of eligibility for an individual or family determines the delivery system – RIte Care or RHP – in which a person must enroll (See Medicaid Code of Administrative Rules, Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways (Subchapter 00 Part 1 of this Chapter).

1. Enrollment channels – Once determined eligible, a Medicaid eligible person may enroll in a RIte Care or Rhody Health Partners Plan, as appropriate:

    a. Online through the eligibility portal independently or with a navigator's assistance;

    b. Over the phone with a Contact Center representative; or

    c. In-person at the Contact Center or a DHS office. (Contact information located in § 2.67 of this Part).

2. Information on enrollment options – The EOHHS and the RIte Care and RHP MCOs share responsibility for ensuring Medicaid applicants and prospective and current enrollees have access to accurate up-to-date information about their enrollment options. This information is available online if applying through the eligibility web portal, as well as through the Contact Center, EOHHS, DHS and the participating MCOs. The information available must include:

a. Materials describing the Medicaid managed care delivery system.

b. A written explanation of enrollment options including information about the applicable service delivery system – RIte Care versus RHP – and choice of participating MCOs therein.

c. Upon requested, an indication of whether a prospective enrollee's existing physician is a participant in each of the respective MCOs.

d. Non-biased enrollment counseling through the Contact Center or a Navigator.

e. A chart comparing participating MCOs.

f. Detailed instructions on how to enroll.

g. Full disclosure of any time limits and consequences for failing to meet those time limits.

h. Access to interpreter services.

i. Notification in writing of the right to challenge auto-assignment for good cause through EOHHS.

3. Non-biased enrollment counseling – Non-biased enrollment navigators who are not affiliated with any participating MCO help enrollees choose an MCO and a primary care provider (PCP) capable of meeting their needs. Factors that may be considered when making this choice are whether an existing PCP participates in a particular MCO, as well as language preferences or limitation, geographic proximity, and so forth. Enrollment navigators are available by telephone or in-person at the Contact Center and DHS offices during regular hours of operation. They also are available in-person and by telephone at these locations to assist enrollees who would like to change MCO, such as, during open enrollment or due to good cause).

4. Voluntary selection of MCO – Prospective enrollees are given fourteen (14) calendar days from the completion of their eligibility determination to select an MCO. All members of a family must select the same MCO. If an individual or family does not select an MCO within the time allowed, the individual or family is automatically assigned to an MCO.

5. Automatic assignment into an MCO – The State employs a formula, or algorithm, to assign prospective enrollees who do not make a voluntary selection into an MCO. This algorithm considers quality and financial performance.

6. Requests for reassignment – Medicaid enrollees who have selected an MCO voluntarily or have been auto-assigned may request to be reassigned within certain limits. Such requests are categorized as follows:

   a. Requests made within ninety (90) days of enrollment. Medicaid members may be reassigned to the MCO of their choice if their oral or written request for reassignment and their choice of an alternative MCO is received by EOHHS within ninety (90) days of the voluntary or auto-assigned enrollment and the MCO selected is open to new members. The effective date of an approved enrollment must be no later than the last day of the second (2nd) month following the month in which the enrollee requests disenrollment or the MCO requests.

   b. Requests made ninety (90) days or more after enrollment. Medicaid enrollees who challenge an auto-assignment decision or seek to change MCOs more than ninety (90) days after enrollment in the health plan must submit an oral or written request to EOHHS and show good cause, as provided in § 2.48(A)(4) of this Part, for reassignment to another MCO. A written decision must be rendered by EOHHS within ten (10) days of receiving the request and is subject to appeal.

   c. Open Enrollment. A Medicaid enrollee may request to be reassigned to another MCO once every twelve (12) months without good cause shown.

7. Auto-assignment and resumption of eligibility – Medicaid members who are disenrolled from an MCO due to loss of eligibility and who regain eligibility within sixty (60) calendar days of disenrollment are automatically re-enrolled, or assigned, into the same MCO if they do not make an MCO selection upon reinstatement of their Medicaid eligibility. If more than sixty (60) days has elapsed and the Medicaid member does not make an MCO selection at the time eligibility was reinstated, the Medicaid member will be auto-assigned to an MCO based on EOHHS's algorithm referenced in § 2.36(A)(5) of this Part.

8. Open-enrollment – To the extent feasible, EOHHS must coordinate open enrollment periods with those established for affordable care more generally through the State's health insurance exchange – HealthSource RI.

9. EOHHS reserves the discretion to provide Medicaid wrap around coverage, as an alternative to coverage in a Medicaid MCO to any eligible individual who has comprehensive health insurance through a liable third party, including (but not limited to) absent parent coverage. Such wrap around coverage must be equivalent in scope, amount and duration to that

provided to Medicaid eligible individuals enrolled in in a qualified health plan, including ESI, through the RIte Share program. (Medicaid Code of Administrative Rules, RIte Share Premium Assistance Program (Part 3 of this Subchapter).

2.37 Enrollment of Newborns and Adopted Children

A. RHP members remain enrolled in their current plan until the time of renewal or the birth of the child or the end of the pregnancy, whichever comes first.

1. Newborns – Infants born to mothers with income up to two hundred fifty-three percent (253%) of FPL who are enrolled in an MCO on the date of their baby's birth are automatically enrolled into a RIte Care MCO. If the newborn's mother is enrolled in a RIte Care MCO, the child is automatically enrolled in the mother's MCO. If the newborn's mother is enrolled in a RHP MCO, the baby and the mother will be enrolled in a RIte Care MCO, effective on the date of birth, once certification of the birth has been received. If the newborn's mother is enrolled in an ESI or other qualified health plan (QHP) with a Medicaid wrap, the baby is enrolled in RIte Care or RIte Share if the plan meets the cost-effectiveness test set forth in the Medicaid Code of Administrative Rules, RIte Share Premium Assistance Program (Part 3 of this Subchapter) See Medicaid Code of Administrative Rules, Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways (§ 00-1.7(A) of this Chapter) for newborn deeming provisions.

2. Adopted children – Enrollment of adopted children who are eligible on their own or as part of a Medicaid eligible family also varies depending on the basis of Medicaid coverage. Legally adopted children are enrolled as of the date the adoption becomes final. This date cannot be prior to the date Medicaid eligibility is established. The applicable provisions on eligibility and enrollment of child participating the State's adoption subsidy program are located in, Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways (Subchapter 00 Part 1 of this Chapter). A parent, caretaker or guardian must notify EOHHS when a newborn deemed eligible is adopted.

3. Other Infants and Children – All infants and children with income up to the two hundred sixty-one percent (261%) of the FPL level are Medicaid eligible under the MACC group for children and young adults, irrespective of the eligibility of a parent, caretaker or pregnant mother as indicated in the provisions in, Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways (Subchapter 00 Part 1 of this Chapter). Any infants and children determined eligible on this basis are enrolled in a RIte Care or, as applicable, RIte Share-approved ESI health plan in accordance with the provisions of this rule applicable to all other Medicaid members.

2.38 Medicaid Members Exempt from Enrollment Managed Care

A. Certain Medicaid members who would otherwise receive care through the RIte Care or RHP delivery systems may be granted exemptions from mandatory enrollment in an MCO for good cause in narrow range of "extraordinary circumstances" upon approval of EOHHS. An extraordinary circumstance, as defined for these purposes, is a situation, factor or set of factors that preclude a Medicaid member from obtaining the appropriate level of medically necessary care through the managed care delivery system – RIte Care or RHP – designated for the Medicaid member's coverage group.

1. Types of extraordinary circumstances – Such a situation, factor or set of factors may include the existence of a chronic, severe medical condition for which the member has a longstanding treatment relationship with a licensed health care practitioner who does not participate in any of the Medicaid MCOs in the delivery system designated to provide care to the member.

2. Limits – A Medicaid member's preference to continue a treatment relationship with a particular physician or other health care practitioner who does not participate with an MCO in the member's designated delivery system does not constitute an "extraordinary circumstance" in and of itself.

3. Exemption requests – Requests for exemption to mandatory enrollment in managed care due to extraordinary circumstances must be made in writing, include appropriate documentation (letter from physician, medical records, or other as indicated), and signed. Exemption requests should be routed to EOHHS.

4. Agency actions and duration of exemption – EOHHS makes enrollment exemption determinations based on a consideration of the circumstances of each member's individual request. Once exempted, an individual can be exempt for as long as the extraordinary circumstance exists. Non-exempt Medicaid members in a household must follow the regular Medicaid MCO enrollment process.

2.39 MCO Lock-In

A. Following initial enrollment into an MCO, Medicaid members are restricted to that MCO until the next open enrollment period. During this health plan lock-in, a Medicaid member may request to be reassigned to another MCO only under one of a set of specific allowed conditions.

1. Allowed conditions for reassignment requests – Members may request to be reassigned to another MCO for any of the following reasons:

a. Substandard or poor quality care;

b. Inadequate access to necessary specialty services;

c. Lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs;

d. The MCO does not, because of moral or religious objections, cover the services the enrollee seeks;

e. The enrollee needs related services to be performed at the same time; not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

f. Insufficient transportation;

g. Discrimination;

h. Member relocation;

i. Good cause as defined in § 2.48(A)(4) of this Part.

j. Without cause during the ninety (90) days following the effective date of the Medicaid member's initial enrollment with the MCO.

2. Process for requesting reassignment – Medicaid members seeking MCO reassignment during the lock-in period must file a formal request with EOHHS.

3. Agency review – MCO reassignment can only be ordered by EOHHS after administrative review of the facts of the case. In the course of the review, EOHHS must examine the evidence it has compiled about the grounds that are the basis for the Medicaid member's request for disenrollment.

4. Notice of agency action – EOHHS must provide the member with written notice of the action taken on the request for MCO reassignment. If EOHHS determines that there is sufficient evidence to reassign the Medicaid member, the notice must be sent to the member at least ten (10) days prior to the date the proposed reassignment would be effective. The Medicaid member must submit a plan change form to select another MCO.

2.40 Open Enrollment

During an open enrollment period, Medicaid members have an opportunity to change MCOs. Open enrollment extends to all RHP enrollees and RIte Care enrollees, with the exception of members in the Extended Family Planning coverage group and foster care children who are receiving foster care or adoption subsidy assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement.

2.41 Membership Handbook

The Medicaid MCO must provide a Medicaid enrollee with a membership handbook and information on how to select a primary care provider member. This information must be sent by mail within ten (10) days of the date of enrollment for all members excluding foster children.

2.42 Identification Cards

A. Medicaid members are issued two identification cards – permanent MCO cards and permanent Rhode Island Medicaid cards.

1. MCO permanent cards – Medicaid MCOs must issue permanent identification cards to all Medicaid members within ten (10) days of the date the enrollment was received by the MCO. The card identifies the MCO name and a twenty-four (24) hour, toll-free telephone number for the Medicaid member to call in the event of an urgent or emergent health care problem. The card also includes the telephone number for the MCO's membership services division and may include the name and telephone number of the recipient's primary care provider.

2. Medicaid cards – A Rhode Island Medicaid identification card is also issued to Medicaid members who are eligible for out-of-plan benefits through the State's Medicaid Management Information System (MMIS).

2.43 Interim Fee-for-Service Coverage

For RIte Care members only, there is a seven (7) day period between Medicaid MCO assignment and MCO enrollment in which services provided to a Medicaid member may be paid for on a fee-for-service basis. The services must be delivered to the Medicaid member by a health provider or practitioner certified to participate in the Rhode Island Medicaid program to qualify for the fee-for service payment. Services delivered prior to MCO enrollment to a pregnant woman who is otherwise ineligible for Medicaid with income above two hundred fifty-three percent (253%) of the FPL are not covered.

2.44 Verification of Eligibility/Enrollment

Medicaid MCO have the opportunity to contact EOHHS, a DHS office, the automated enrollment mailbox utilized by the health plans, or the automated eligibility verification system as necessary and appropriate to verify eligibility and plan enrollment if a Medicaid member requires immediate services.

2.45 Responsibility of Medicaid Members to Report Change in Status

Medicaid members are responsible for reporting certain changes in status including any related to family size, residence, income, employment, third (3rd) party coverage, and child support. Such information must be filed with EOHHS, the Contact Center or a DHS field office within ten (10) days of the date the change occurs. In addition, EOHHS conducts periodic reviews to determine whether any changes in status have occurred that affect eligibility or health plan enrollment. Medicaid MCOs must also report to EOHHS any changes in the status of Medicaid members once they become known.

2.46 Transitioning Members between MCOs and Delivery Systems

A. It may be necessary to transition a Medicaid member between MCOs or from one (1) delivery system – RHP to RIte Care or vice versa – for a variety of reasons:

1. Change in MCOs within a delivery system – The transition between Medicaid MCOs may occur as a result of change in MCO during open enrollment or a change that is ordered as part of a grievance resolution. The MCOs have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when transitioning a member to or from another MCO. The MCO must transfer this information at no cost to the member.

2. Change in delivery systems – Medicaid members may be transitioned from one managed care delivery system into another as a result of changes in eligibility status. Adults enrolled in RIte Care who are between the ages of nineteen (19) and sixty-four (64) may be eligible under the MACC group for adults when their dependent children age out of MACC group for children and young adults. Once a RHP member has given birth, both newborn and/or parents may be transitioned to RIte Care if income is within the eligibility thresholds set forth in Medicaid Affordable Care Coverage Groups Overview and Eligibility Pathways (Subchapter 00 Part 1 of this Chapter). Enrollment in MCOs during such transitions will strive to preserve the continuity of care to the full extent feasible. Accordingly, Medicaid members enrolled in a particular MCO subject to a delivery system transition will be enrolled in the same health plan, if participating, in the new delivery system.

2.47 Grievances, Appeals, and Hearings

The State provides a grievance and appeals process that MCO providers and Medicaid enrollees must use when seeking redress against health plans. This is the same process that the MCOs must use when seeking to disenroll members who are habitually non-compliant or who pose a threat to plan employees or other members. See Part 10-05-2 of this Title, Appeals Process and Procedures for EOHHS Agencies and Programs, for additional information.

2.48 MCO Initiated Disenrollment

A. The MCO may seek disenrollment of a member who is habitually non-compliant or poses a threat to MCO employees or other members. An MCO initiated disenrollment, is subject to an administrative review process by EOHHS and must follow the following requirements:

1. MCO disenrollment requests – For an MCO to disenroll a Medicaid member, the MCO must send a request, along with accompanying documentation, to EOHHS. When the request is received, EOHHS sends a notice to the Medicaid member informing him or her that the MCO is seeking to take a disenrollment action and explaining the reason given by the MCO for taking such an action. The notice also informs the member that of the right to submit within ten (10) days any evidence establishing a good cause appeal rejecting the disenrollment action.

2. Additionally, the MCO must:

   a. Specify the reasons for which the MCO is requesting disenrollment of an enrollee;

   b. Not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs (except when his/her continued enrollment in the MCO seriously impairs the MCO's ability to furnish services to either this particular enrollee or other enrollees).

   c. Specify the methods by which the MCO assures EOHHS that it does not request disenrollment for reasons other than those permitted under the managed care contract.

3. EOHHS action -- EOHHS must investigate and render a decision within ten (10) days of receipt of evidence from both parties. EOHHS's decision is subject to appeal. If, based upon the evidence submitted by the health plan, EOHHS determines that the Medicaid member should be disenrolled from the health plan, a notice is sent to the Medicaid member by EOHHS

stating the decision and the basis thereof at least ten (10) days prior to the date the proposed disenrollment would be effective.

4. Good Cause appeal – A Medicaid member subject to a health plan request for disenrollment has the right to present evidence establishing good cause. Good cause must be filed prior to the end of the ten (10) day advance notice period. The filing of good cause is submitted in writing to EOHHS. Good cause includes circumstances beyond the Medicaid member's control sufficiently serious to prevent compliance; an unanticipated household emergency; a court-required appearance; incarceration; breakdown in transportation arrangements; or inclement weather which prevented the Medicaid member and other persons similarly situated from traveling to, or participating in, the required appointment. A member's preference to remain in fee-for-service does not constitute good cause for an appeal of the request for disenrollment.

2.49 EOHHS Authority

EOHHS has sole authority as the Medicaid Single State Agency for disenrolling Medicaid members from an MCO. Requests for disenrollment, either as the result of a formal grievance filed by the Medicaid member against the MCO, or by the MCO against the Medicaid member, is subject to an administrative review process by EOHHS.

2.50 Reasons for Disenrollment

A. EOHHS may disenroll Medicaid eligible MCO members for a variety of reasons including, but not limited to, any of the following:

1. Death;

2. Loss of eligibility;

3. Selection of another MCO during open enrollment;

4. Change of residence outside of the MCO's service area;

5. Non-payment of premium share;

6. Incarceration;

7. Permanent placement in Eleanor Slater Hospital;

8. Long-term placement in a nursing facility for more than thirty (30) days (does not apply to RIte Care members);

9. Disenrollment as the result of a formal grievance filed by the member against the MCO; or

10. Disenrollment as the result of a formal grievance filed by the MCO against the member.

2.51 Disenrollment Effective Dates

Member disenrollments outside of the open enrollment process become effective on the date specified by EOHHS, but not fewer than six (6) days after the MCO has been notified, unless the MCO waives this condition. The MCOs have written policies and procedures for complying with EOHHS disenrollment orders.

2.52 Right to Appeal

All notifications of disenrollment must include information regarding the Medicaid member's right to appeal the decision and the procedures for requesting an EOHHS administrative fair hearing.

2.53 Medicaid Member Rights and Protections

A. All Medicaid members are guaranteed access to quality health care delivered in a timely and respectful manner. To ensure this goal is met, the following rights and protections must be clearly stipulated by both EOHHS and the MCO.

1. Enrollment – EOHHS will make every effort to provide the following:

    a. Multilingual services to all people who do not speak English;

    b. Written enrollment information will be provided in a clear and easy-to-understand format;

    c. Enrollment information provided by the MCO must include detailed information on how to obtain transportation services, second opinions, interpreter services, referrals, emergency services and out-of-State services unavailable in Rhode Island. Information must also be provided regarding switching primary care providers, disenrollment for good cause, the in-plan grievance process and the EOHHS appeals process;

    d. The State will conduct a special enrollment outreach effort for beneficiaries who are homeless or who live in transitional housing;

    e. Once a Medicaid member is enrolled, the MCO will conduct a special enrollment outreach effort for any enrollees who are homeless or who live in transitional housing;

    f. The MCO is prohibited from engaging in any door-to-door or telemarketing or any other similar unfair marketing practices;

g. Enrollees will be provided with counseling assistance in the selection process for their primary care providers;

h. Medicaid members who receive on-going care from a primary care provider or specialist will be advised by the non-biased enrollment counselor which providers are participating in each MCO option so as to promote continuity of care;

i. If a Medicaid member is auto-assigned to an MCO, the member, within ninety (90) days, may dispute that assignment through the right to rebuttal. A decision by EOHHS must be rendered within ten (10) days of the filing of the rebuttal and is subject to appeal.

2. Second Opinions and Switching Doctors – Every Medicaid member must be informed of the following:

a. MCOs must provide, at their expense, a second (2nd) opinion within the MCO upon an enrollee's request. A decision on the request for a second (2nd) opinion will be made in a timely manner and approval shall not be unreasonably withheld;

b. A Medicaid member is entitled to a second (2nd) surgical opinion by a plan physician, or if the referral is made by a plan physician, to a second (2nd) surgical opinion by a non-participating physician;

c. Medicaid members have the right to switch providers within the MCO, upon request.

d. Members who are denied a second (2nd) opinion or denied the right to switch providers will have the right to appeal, as set forth in Part 10-05-2 of this Title, Appeals Process and Procedures for EOHHS Agencies and Programs for additional information.

3. Disenrollment – The following apply to requests for disrenrollment, as indicated:

a. Medicaid members may request to disenroll from any MCO for the remainder of an enrollment period for any of the reasons established in § 2.34 of this Part;

b. A rapid disenrollment process must be provided for individuals and families who are dislocated and move to another area due to homelessness, domestic abuse, or other similar crises, if they cannot access in-plan services within a reasonable distance from their new location;

4. Interpreter Services – Plans are encouraged to provide availability to twenty-four (24) hour interpreter services for every language group

enrolled by the health plan for all points of contact, especially telephone contact. In addition, reasonable attempts must be made by the plans to have written materials, such as forms and membership manuals, translated into other languages. If the health plan has more than fifty (50) members who speak a single language, it must make available general written materials, such as its member handbook, in that language. Interpreter services are provided if a plan has more than one hundred (100) members or ten percent (10%) of its Medicaid membership, whichever is less, who speak a single language other than English as a first language.

a. Written material must be available in alternative formats, such as audio and large print, and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services. All enrollees must be informed that information is available in alternative formats and how to access those formats.

5. Exceptions Based on Safety Needs – Providers, MCOs and the State must consider the personal safety of a beneficiary in instances of domestic violence in all of the following matters:

a. Enrollment policies;

b. Disenrollment policies;

c. Second (2nd) opinions;

d. Switching primary care physicians/practitioners; and

e. Grievance procedures.

6. Referral to Rhode Island Legal Services – Notices to Medicaid members must include information indicating that they may represent themselves or be represented by someone else such as a lawyer, relative, or another person in the hearing and appeal process. Notices must also provide information regarding free legal help available at Rhode Island Legal Services.

2.54 Pharmacy Home Program

A. The objective of the Pharmacy Home Program is to prevent members from obtaining excessive quantities of prescribed medications through visits to multiple

prescribers and pharmacies and improving health outcomes. Participants enrolled in the program are required to obtain all medications from a specific pharmacy location otherwise known as a “Pharmacy Home” for a period of two (2) years.

B. The EOHHS, or its contracted MCO, will establish criteria to identify members for inclusion in the Pharmacy Home Program. Members will be notified at least thirty (30) days prior to enrollment in the program.

C. Select provider referrals are available as part of the Pharmacy Home Program. The EOHHS, or its contracted MCO, will ensure that members with complex medical and/or behavioral health needs are connected with high quality select providers to meet those needs. Members who use multiple providers and have one or more complex medical conditions and chronic diseases shall be referred as needed to a select provider.

2.55 Rite Smiles Dental Plan Overview

A. The RIte Smiles Program is a statewide dental benefits managed care delivery system established under a Federal waiver. The program's goal is to improve access to oral health services for Rhode Island children who receive Medicaid. Emphasis is placed on preventive and primary care dental services and education.

B. Children born on or after May 1, 2000 who are receiving dental benefits through Medicaid are enrolled in a RIte Smiles dental plan. EOHHS contracts with one (1) or more dental plans to provide oral health services to these Medicaid-eligible children.

2.56 Legal Authority

Title XIX of the Social Security Act provides the legal authority for the Medicaid Program. The RIte Smiles Program operates under a waiver under the authority of Section 1115 of the Social Security Act.

2.57 Coverage Groups

A. Participation in the RIte Smiles Program is mandatory for all children in the following populations who were born on or after May 1, 2000 and who are receiving Medicaid:

1. Section 1931 children and related populations (including poverty level groups and RI Works cash recipients);

2. Blind and/or disabled children;

3. Foster care children who are receiving foster care or adoption subsidy assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement;

4. Section 1115 Waiver Children.

2.58 Excluded Coverage Groups

A. The following groups are excluded from participation in the RIte Smiles Program:

1. Children born on or before April 30, 2000;

2. Children who have access to third (3rd) party dental benefits;

3. Children who reside in nursing facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID).

4. Children who reside outside of the State of Rhode Island. Those children who are not eligible to participate in the RIte Smiles Program receive dental benefit coverage under the fee-for-service system.

2.59 Retroactive Eligibility

If a member is eligible for retroactive eligibility, the dental plan does not provide coverage to Medicaid beneficiaries during the period of retroactive eligibility.

2.60 Enrollment Process

A. All children determined eligible for Medicaid who were born on or after May 1, 2000 must enroll in a RIte Smiles Program dental plan. The parent(s) or guardian(s) of the eligible children may have a choice of dental plans, if more than one (1) plan is available, in which to enroll.

B. The enrollment process insures that applicants/beneficiaries are provided with sufficient information (if a choice of dental plan is available) in order to make an informed choice when deciding upon which RIte Smiles plan to choose.

2.61 Voluntary Selection of a Dental Plan

Newly eligible children for RIte Care, RIte Share, or fee-for service Medicaid will be given a choice of RIte Smiles plans on their Medicaid application.

2.62 Auto Re-Enrollment Following Resumption of Eligibility

Members of families who receive Medicaid and who are disenrolled from a dental plan due to loss of eligibility are automatically re-enrolled, or assigned, into the same plan should they regain eligibility within sixty (60) calendar days. If more

than sixty (60) days has elapsed, the family is permitted to select a plan from those open for enrollment at that time.

2.63 Rite Smiles Lock-In

A. After initial enrollment into a RIte Smiles plan, enrollees are restricted to that dental plan until the next open enrollment period, unless disenrolled under one (1) of the conditions described below:

1. Loss of Medicaid eligibility, including for non-payment of applicable premium shares for RIte Care or RIte Share;

2. Selection of another dental plan during open enrollment, if another plan exists;

3. Death;

4. Relocation out-of-State;

5. Adjudicative actions;

6. Change of eligibility status;

7. Eligibility determination error;

8. As the result of a formal grievance filed by the member against the dental plan or by the dental plan against the member;

9. Just cause (as determined by EOHHS).

2.64 Open Enrollment

During open enrollment members have an opportunity to change RIte Smiles dental plans, if more than one (1) dental plan is available.

2.65 Voluntary Disenrollment

A. RIte Smiles members seeking disenrollment during the lock-in period must first file a formal appeal pursuant to appeal procedures with the dental plan (with the exception that members are permitted to disenroll without cause during the ninety (90) days following the effective date of the individual's initial enrollment, if more than one (1) dental plan is available).

B. Disenrollment can only be ordered by EOHHS after administrative review of the facts of the case. In order for disenrollment to occur, EOHHS must first find in favor of the member, and then determine that the appropriate resolution to the member's complaint is the member's disenrollment.

2.66 Member Disenrollment

A. Unless the member's continued enrollment in the dental plan seriously impairs the dental plan's ability to furnish services to either the particular member or other members, a RIte Smiles dental plan may not request disenrollment of a member because of:

1. An adverse change in the member's health status;

2. The member's utilization of medical/dental services; or

3. Uncooperative or disruptive behavior resulting from the member's special needs. All disenrollments are subject to approval by EOHHS.

2.67 Information and Referral

A. For Further Information or to Obtain Assistance:

1. www.eohhs.ri.gov

2. www.dhs.ri.gov

3. www.HealthSourceRI.com

B. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

C. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

2.68 Severability

If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.