



RHODE ISLAND EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

Notice of Public Review of Rules and Public Hearing

The Secretary of the Executive Office of Health & Human Services (EOHHS) has under consideration the repeal of the Medicaid Code of Administrative Review ("MCAR") Sections 0374/0375 entitled, "Community Supported Living Arrangements and Integrated Care Program" and MCAR Section 0399.21 entitled, "Program for All-Inclusive Care for the Elderly (PACE)." These rules will be superseded by a newly adopted MCAR Section #1475 entitled, "Managed Care Service Delivery Options for Elders and Adults with Disabilities and Long-Term Care Beneficiaries."

All of these regulations are promulgated pursuant to the authority contained in Rhode Island General Laws Chapters 40-8 (Medical Assistance); 42-7.2 (Executive Office of Health & Human Services) and 40-6 (Public Assistance Act); Title XIX of the Social Security Act; and the Medicaid Section 1115 Demonstration Waiver.

In the development of these proposed Regulations, consideration was given to the following: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small businesses in Rhode Island. No alternative approach, duplication or overlap, or impact upon small businesses was identified based upon available information.

In accordance with RIGL 42-35-3, the Secretary will hold a Public Hearing on all of these regulations on **Monday, June 13, 2016 at 10:00 a.m.** at which time and place all persons interested therein will be heard. The Public Hearing will be convened as follows:

**Monday, June 13, 2016 at 10:00 a.m.
Arnold Conference Center, Eleanor Slater Hospital
John O. Pastore Complex, 111 Howard Avenue
Cranston, RI 02920
(Parking is adjacent to the building).**

All of these proposed documents, including those to be repealed, are accessible on the Rhode Island Secretary of State's website: <http://www.sos.ri.gov/ProposedRules/> or are available in hard copy upon request (401-462-1575 or RI Relay, dial 711). Interested persons should submit data, views, or written comments **by Monday, June 27, 2016** to: Elizabeth Shelov, Office of Policy and Innovation, Rhode Island Executive Office of Health & Human Services, Hazard Building, 74 West Road, Cranston, RI 02920 or Elizabeth.Shelov@ohhs.ri.gov.

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Original signature by:

Elizabeth H. Roberts, Secretary
Signed this 24th day of May 2016

State of Rhode Island & Providence Plantations

Executive Office of Health & Human Services



Access to Medicaid Coverage under the Affordable Care Act

Section 1475:

**Managed Care Service Delivery Options for Elders and
Adults with Disabilities and Long-Term Care
Beneficiaries**

May 2016 (Proposed)

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage under the Title IX of the Social Security Act

Rules and Regulations Section 1475:

Managed Care Service Delivery Options for Elders and Adults with Disabilities and Long-Term
Care Beneficiaries

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Introduction

These rules, Section 1475 of the Medicaid Code of Administrative Rules entitled, “Managed Care Service Delivery Options for Elders and Adults with Disabilities and Long-Term Care Beneficiaries,” are newly adopted and promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 and 40-8.13 (Medical Assistance); Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); and the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15).

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication, or overlap was identified, and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede the Medicaid Code of Administrative Rules, Sections 0374 and 0375: “Community Supported Living Arrangements and Integrated Care Program,” last promulgated by EOHHS and filed with the Rhode Island Secretary of State in May 2014 and MCAR Section 0399.21, in those areas related to the Program for All-Inclusive Care for the Elderly (PACE) plan enrollment, last amended in July 2009.

Managed Care Service Delivery Options for Elders and Adults with Disabilities and Long-Term Care Beneficiaries

Section 1475.00 Managed Care Service Delivery Arrangements

A. Overview of this Rule

These rules entitled, “Section 1475 of the Medicaid Code of Administrative Rules: Managed Care Service Delivery Options for Elders and Adults with Disabilities and Long-Term Care Beneficiaries,” are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapters 40-8 and 40-8.13 (Medical Assistance); Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); and the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15).

This rule shall supersede Medicaid Code of Administrative Rules, Sections 0374 and 0375: “Community Supported Living Arrangements and Integrated Care Program,” last promulgated by EOHHS and filed with the Rhode Island Secretary of State (SOS) in May 2014 and Section 0399.21 in those areas related to the Program for All-Inclusive Care for the Elderly (PACE) plan enrollment originally adopted and filed with the SOS in July 2009.

With the enactment of the federal Affordable Care Act of 2010, Medicaid eligibility groups were reorganized into two categories based on whether their eligibility must be determined using the Modified Adjusted Gross Income (MAGI) standard or the more comprehensive requirements associated with the Supplemental Security Income (SSI) program that consider income as well as certain characteristics – i.e., age, disability and blindness. For the purposes of clarity, the State has designated all MAGI-eligible populations as Medicaid Affordable Care Coverage (MACC) groups and consolidated all rules related to these groups in a new chapter of the Medicaid Code of Administrative Rules (MCAR) – Section 1300 *et seq.*

Beneficiaries subject to the more comprehensive SSI income standards – elders and adults with disabilities (commonly referred to as aged, blind, and disabled adults) and beneficiaries receiving long-term services and supports (LTSS) – are referred to hereafter as the Integrated Health Care Coverage (IHCC) groups.

The purpose of this rule is to set forth in clear language the respective roles and responsibilities of the Executive Office of Health and Human Services (EOHHS), beneficiaries and the contractual entities serving IHCC groups and some MACC groups enrolling in and receiving services through managed care. This rule makes reference to the eligibility requirements for members of these groups in effect as of April 1, 2016 pending completion of two new chapters of the MCAR – 1400 and 1500 – updating and consolidating rules related to health coverage and LTSS for IHCC groups.

Overview of Managed Care Programs for Adults with Disabilities and Elders

<i>Program</i>	Rhody Health Partners	ICI Phase I – Rhody Health Options		ICI Phase II - Medicare-Medicaid Plan	PACE
<i>Population</i>	Elders and adults with disabilities who do not have Medicare or other third-party coverage and are not eligible for LTSS	Adult Medicaid beneficiaries who do not have Medicare and are eligible for LTSS	Adults who have full Medicare and full Medicaid coverage	Adults who have full Medicare and full Medicaid coverage	Adult Medicaid beneficiaries age 55 and older who qualify for a nursing home level of care
<i>Mandatory/Voluntary Enrollment</i>	Mandatory	Voluntary	Voluntary	Voluntary	Voluntary
<i>Covered Services</i>	Medicaid	Medicaid	Medicaid	Medicaid and Medicare Parts A, B, and D	Medicaid and Medicare Parts A, B, and D (if eligible)
<i>Participation Criteria</i>	<ul style="list-style-type: none"> • Age 21 and older; and • Eligible for Medicaid on the basis of the SSI income standard (IHCC group) 	<ul style="list-style-type: none"> • Age 21 and older; • Eligible for Medicaid on the basis of the SSI income standard (IHCC group) or the MAGI income standard (MACC group); and • Receive LTSS 	<ul style="list-style-type: none"> • Age 21 and older; • Eligible for Medicaid on the basis of the SSI income standard (IHCC group) or the MAGI income standard (MACC group); and • Eligible for full Medicare benefits 	<ul style="list-style-type: none"> • Age 21 and older; • Eligible for Medicaid on the basis of the SSI income standard (IHCC group) or the MAGI income standard (MACC group); and • Eligible for full Medicare benefits 	<ul style="list-style-type: none"> • Age 55 years and older; • Meet criteria for high or highest need for a nursing facility level of care; and • Meet all other requirements for LTSS
<i>Exemption Criteria</i>	<ul style="list-style-type: none"> • Age 19-21; or • Determined eligible for Medicaid as medically needy 	<ul style="list-style-type: none"> • Age 19-21 	<ul style="list-style-type: none"> • Age 19-21; or • Determined eligible for Medicaid as medically needy and not receiving LTSS 	<ul style="list-style-type: none"> • Age 19-21; or • Determined eligible for Medicaid as medically needy and not receiving LTSS 	<ul style="list-style-type: none"> • Under age 55
<i>Exclusion Criteria</i>	<ul style="list-style-type: none"> • Enrolled in Medicare Parts A and/or B; • Have other third-party coverage; or • Receive LTSS for more than 30 days 	<ul style="list-style-type: none"> • Reside in Tavares, Eleanor Slater, or out-of-state hospitals; or • In hospice on the enrollment date 	<ul style="list-style-type: none"> • Not eligible for full Medicaid benefits; • Not qualified for all segments of Medicare; • Reside in Tavares, Eleanor Slater, or an out-of-state hospital; or • In hospice on the enrollment date 	<ul style="list-style-type: none"> • Not eligible for full Medicaid benefits; • Not qualified for all segments of Medicare; • Reside in Tavares, Eleanor Slater, or an out-of-state hospital; • In hospice on the enrollment date; • Reside out-of-state for 6 consecutive months or longer; or • Eligible for the Sherlock Plan 	

B. Definitions

For the purpose of this rule, the following terms are defined as follows:

“Appeal” means a request to review an “adverse benefit determination” based on medical necessity, appropriateness, health care setting, and effectiveness.

“Communities of Care (CoC)” means the special delivery system that provides more intensive care management within a limited network to Medicaid members enrolled in either RItE Care or Rhody Health Partners who have Emergency Department utilization rates at or above the threshold for participation set by the Medicaid agency.

“Community Health Teams (CHT-RI)” means the primary care case management program for adults who have fee-for-service Medicaid coverage and otherwise do not have access to such services.

“Elders and Adults with Disabilities (EAD)” means the Medicaid IHCC group established by §40-8.5 for adults with an SSI characteristic related to age (elders 65 years of age or older) or disability who have income at or below one hundred (100) percent of the federal poverty level.

“Executive Office of Health and Human Services (EOHHS)” means the state agency that is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Title XIX Medicaid Program.

“Full Dual Eligible” means a fully eligible Medicare beneficiary who qualifies for Medicaid health coverage based on income and resources. To participate in the Integrated Care Initiative, a full dual eligible must meet the definition of MME, set forth herein.

“Grievance” means an expression of dissatisfaction about any matter other than an action associated with an adverse benefit determination and includes complaints about the quality of care or services provided, and aspects of interpersonal relations such as rudeness of a provider or an employee or a failure to respect an enrollee’s rights.

“Integrated Health Care Coverage (IHCC) Groups” means any Medicaid coverage group consisting of adults who are eligible on the basis of receipt of Supplemental Security Income (SSI), SSI protected status, the SSI income methodology and a related characteristic (age or disability), or as a result of participation in another federal or State program (e.g., Breast and Cervical Cancer). Includes beneficiaries eligible for community Medicaid (non-long-term care), Medicaid-funded LTSS and the Medicare Premium Payment Program.

“Integrated Care Initiative (ICI)” means a two-phase Medicaid initiative that delivers integrated and coordinated services to certain Medicaid and Medicaid and Medicare dual eligible beneficiaries through a managed care arrangement. Includes services from across the care continuum including primary, subacute and long-term care.

- ICI Phase I – Uses a managed care arrangement to integrate all types of care for LTSS Medicaid beneficiaries and coordinates Medicaid coverage with Medicare services for beneficiaries who are dual eligible.

- ICI Phase II – A federally approved demonstration which uses a managed care arrangement to integrate the financing and delivery of services for certain MME beneficiaries.

“Long-Term Services and Supports (LTSS)” means a spectrum of services covered by the Rhode Island Medicaid program that are required by individuals with functional impairments and/or chronic illness, and includes skilled or custodial nursing facility care, as well as various home and community-based services.

“Managed Care Arrangement (MCA)” means a system that uses capitated financing to deliver high quality services and promote and optimize health outcomes through a medical home. Such an arrangement also includes services and supports that optimize the health and independence of beneficiaries who are determined to need or be at risk for Medicaid funded LTSS. Includes any arrangement under which an MCO is granted some or all of the responsibility for providing and/or paying for long-term care services and supports through a contractual agreement with the Medicaid program.

“Managed Care Organization (MCO)” means an entity that provides health plan(s) that integrate 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.

“Medicaid Affordable Care Coverage (MACC) Groups” means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility as outlined in MCAR, Section 1301.

“Medicaid and Medicare Enrolled (MME)” means full dual eligible or partial dual eligible plus beneficiaries who are receiving Medicaid health coverage, are enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D.

“Medicaid No Medicare (MNM)” means Medicaid beneficiaries without Medicare who meet the financial and clinical criteria for LTSS and, as such, qualify for enrollment in an ICI Phase I health plan.

“Medicaid Code of Administrative Rules (MCAR)” means the collection of administrative rules governing the Medicaid program in Rhode Island.

“Medically Necessary Service” means a medical, surgical or other service required for the prevention, diagnosis, cure, or treatment of a health related condition including any such services that are necessary to prevent a decremental change in either medical or mental health status.

“Medically Needy” means an IHCC group for elders and persons with disabilities who have high medical expenses and income that exceeds the maximum eligibility threshold for Medicaid. For non-LTSS beneficiaries in this coverage group, Medicaid eligibility and coverage occur when the amount they spend on medical expenses meets the medically needy income limit established by the State. For LTSS beneficiaries, excess income must be contributed toward the cost of care. Non-LTSS medically needy beneficiaries are covered on a fee-for-service basis.

“Medicare-Medicaid Plan (MMP)” is an integrated managed care plan under contract with the federal Centers for Medicare and Medicaid Services (CMS) and EOHHS to provide fully integrated Medicare and Medicaid benefits to MME beneficiaries eligible for the ICI Phase II.

“Member or Enrollee” means a Medicaid-eligible person receiving benefits through Rhody Health Partners, Rhody Health Options, a Medicare-Medicaid Plan, or the Program for All-Inclusive Care for the Elderly.

“Partial Dual Eligible” means a low-income Medicare beneficiary who is ineligible for full Medicaid health coverage due to excess income and resources, but who qualifies to receive financial assistance with Medicare premiums and, in some cases cost-sharing, through the State’s Medicare Premium Payment Program (MPPP).

“Partial Dual Eligible Plus” means a low-income Medicare beneficiary with resources below 300% of the SSI limit who qualifies for full Medicaid health coverage based on income in any coverage group – e.g., MAGI eligible parent – financial assistance with Medicare premiums and/cost-sharing through the MPPP. See MCAR, Section 0372.

“Person-centered Planning” is an individualized approach to planning that supports an individual to share his or her desires and goals, to consider different options for support, and to learn about the benefits and risks of each option. Person-centered planning places the individual at the center of decision-making. It is designed to enable people to direct their own services and supports to live a meaningful life that maximizes independence and community participation. Person-centered planning is a process that is directed by the individual, with impartial assistance and supported decision-making when helpful. Person-centered planning teams may include people who are close to the individual, as well as people who can help to bring about needed change for the person and access to appropriate services. However, at all times, the individual is empowered to decide who is part of the planning team. Person-centered planning must meet the requirements of 42 CFR 441.301(c)(1) including, but not limited to, ensuring that a person has sufficient and necessary information in a form he or she can understand to make informed choices, enabling the person to direct the process to the maximum extent possible, and conducting planning meetings at times and in locations that are convenient to the individual.

“Primary Care” means an array of primary, acute, and specialty services provided by licensed health professionals that includes, but is not limited to: health promotion, disease prevention, health maintenance, counseling, patient education, various specialty services and diagnosis and treatment of acute and chronic medical and behavioral health illnesses and conditions in a variety of health care settings (e.g., office, inpatient, care, home care, day care).

“Program of All Inclusive Care for the Elderly (PACE)” means a risk-based managed care service delivery option for beneficiaries who have Medicare and/or Medicaid coverage and meet the financial and clinical criteria for a nursing facility level of long-term services and supports. Beneficiaries must be 55 years or older to participate in this option.

“Rhody Health Options” means the capitated managed care delivery system operating under contract with EOHHS to manage and coordinate the Medicaid covered services and supports for MNM and MME beneficiaries eligible for the ICI Phase I.

“Rhody Health Partners (RHP)” means the Medicaid managed care service delivery option for adults in the IHCC groups that provides primary/acute and specialty care through a medical home that focuses on prevention and promoting healthy outcomes. The rule for RHP for adults 19-64 in the MACC groups is located in MCAR, Sections 1310 and 1311.

“SSI Income Standard” means the basis for determining Medicaid eligibility that uses the definitions and calculations for evaluating income and resources established by the U.S. Social Security Agency for

the Supplemental Security Income program.

“**SSI Protected Status**” means the class of beneficiaries who retain categorical eligibility for Medicaid even though they are no longer eligible for SSI due to certain changes in income or resources.

1475.01 Medicaid Primary Managed Care

A. Authority and Scope

In 2005, R.I.G.L. §40-8.5-1.1 authorized the Medicaid agency to establish mandatory managed care delivery systems for adults nineteen (19) years of age or older who are eligible on the basis of participation in the Supplemental Security Income (SSI) program (see MCAR, Section 0356 to 0370) or an SSI-related characteristic associated with age or a disability and income. In Rhode Island, persons with SSI-related characteristics are eligible under the Medicaid State Plan option for low-income elders and adults living with disabilities (EAD) in accordance with R.I.G.L. §40-8.5 (MCAR, Section 0372). The requirements for adults in associated special eligibility groups that have unique financial (e.g., SSI Protected Status) or clinical criteria (e.g., breast and cervical cancer coverage group) or limited benefits (e.g., partial dual eligible group and the Medicare Premium Payment Program) are also located in MCAR, Section 0372.

Beneficiaries eligible in these coverage groups who do not require LTSS are sometimes referred to as “Community Medicaid” and are members of the State’s Integrated Health Care Coverage (IHCC) groups. The provisions governing eligibility set forth in MCAR, Sections 0356 to 0372 and enrollment as established herein will remain in effect unless or until replaced in conjunction with implementation of RI Bridges, EOHHS’ integrated eligibility system, in July 2016.

IHCC group beneficiaries who are eligible on the basis of SSI income standard, do not require LTSS, and do not have third-party coverage are subject to mandatory enrollment in a Rhody Health Partners (RHP) Medicaid managed care plan.

B. EOHHS Responsibilities

EOHHS or its designee is responsible for determining the eligibility of members of the IHCC groups in accordance with requirements established in the applicable sections of federal and State laws, rules and regulations through RI Bridges unless deemed eligible by virtue of receipt of SSI. In general, persons applying through RI Bridges will be informed of their enrollment options at the time a determination of eligibility is made.

IHCC group beneficiaries who are eligible on the basis of SSI income standard, do not require LTSS, and do not have third-party coverage are subject to mandatory enrollment in an RHP Medicaid managed care plan. EOHHS enters into contractual arrangements with the MCOs offering RHP plans that assure access to high quality Medicaid covered services and supports. EOHHS is also responsible for informing beneficiaries of their service delivery options and initiating enrollment in a participating RHP plan.

C. RHP Enrollees

Enrollment in an RHP plan typically occurs no more than thirty (30) days from the date of the determination of eligibility unless excluded or exempted as indicated below.

- (1) **Excluded from RHP enrollment.** Beneficiaries in the following categories are excluded from enrollment in an RHP plan as indicated and may be enrolled in an alternative Medicaid managed care arrangement:
 - (a) **Third-Party Coverage** – SSI and EAD eligible beneficiaries who are enrolled in Medicare Parts A and/or B or have other third-party coverage are not subject to mandatory enrollment in an RHP plan.
 - (b) **Receiving Medicaid-funded LTSS** – Medicaid and MME beneficiaries who require LTSS for more than thirty (30) days are voluntarily enrolled in an RHO plan. This includes newly eligible members of the IHCC groups and RHP enrollees subsequent to receipt of thirty (30) continuous days of LTSS in-plan. MME beneficiaries requiring LTSS can also enroll in an LTSS managed care arrangement through Phase II of the Integrated Care Initiative if eligible.
- (2) **Exempt from Mandatory Enrollment**– The following beneficiaries are not required to enroll in a Medicaid managed care plan:
 - (a) **Exempt Due to Age** – SSI and EAD beneficiaries who are between the ages of nineteen (19) and twenty-one (21) are exempt from mandatory enrollment in an RHP and receive all Medicaid health coverage on a fee-for-service basis.
 - (b) **Medically Needy Eligible, Non-LTSS** – Beneficiaries who are determined eligible as medically needy due to excess income and resources are also exempt from enrollment in managed care. Medicaid health coverage for beneficiaries in this category is provided in accordance with the provisions of MCAR, Section 0368.

During the period while awaiting plan enrollment, beneficiaries receive health coverage on a fee-for-service basis.

D. Timeframe for Enrollment Decisions

A reasonable timeframe is allowed for the beneficiary to review and make an enrollment decision. At the end of this timeframe, EOHHS enrolls the beneficiary as follows:

- (1) **Beneficiary Action** – If the beneficiary makes a choice, EOHHS initiates enrollment, as appropriate, into a participating RHP plan.
- (2) **No Beneficiary Action** – If a beneficiary does not respond within the allotted timeframe, the beneficiary is enrolled in RHP and given the option to change MCO during the first ninety (90) days of enrollment.
- (3) **Delivery System Changes** – Enrollment into RHP is always prospective in nature. Medicaid beneficiaries are required to remain enrolled in this service delivery option, but are authorized to transfer from one MCO to another once a year during an open enrollment period. If a beneficiary becomes eligible for LTSS or Medicare, EOHHS initiates RHP disenrollment and offers the alternative option of enrolling in Medicaid LTSS managed care arrangements such as Rhody Health Options, the Program for All-Inclusive Care for the Elderly (PACE), a Medicare-Medicaid, Plan, or a fee-for-service (FFS) alternative.

- (4) **Auto Re-Assignment after Resumption of Eligibility** – Medicaid beneficiaries who are disenrolled from RHP due to a loss of eligibility are automatically re-enrolled, or assigned, back into the managed care service delivery option they were in previously if they regain eligibility within sixty (60) calendar days. If more than sixty (60) calendar days have elapsed, the enrollment process will follow the process established in subsection (1) or MCAR, Section 1311, entitled “Enrollment Process: Rite Care and Rhody Health Partners Managed Care Plans,” as appropriate.

E. RHP Member Disenrollment

Disenrollment from an RHP plan may be initiated by EOHHS or the plan in a limited number of circumstances as follows:

- (1) **EOHHS Initiated Disenrollment** – Reasons for EOHHS initiated disenrollment from an RHP plan include but are not limited to:
- Death;
 - No longer Medicaid eligible;
 - Eligibility error;
 - Enrolled in Medicare or other third-party coverage;
 - Placement in a long-term care institution – e.g., nursing facility – for more than thirty (30) consecutive days;
 - Placement in Eleanor Slater, Tavares, or an out-of-state hospital;
 - Incarceration; and
 - Eligibility for Medicaid LTSS in the community or in a facility.
- (2) **Member Disenrollment Requested by RHP plan** – An RHP plan may request in writing the disenrollment of a member whose continued enrollment seriously impairs the plan’s ability to furnish services to either the particular member or other members. An RHP plan is not permitted to request disenrollment of a member due to:
- An adverse change in the member's health status;
 - The member's utilization of medical services; or
 - Uncooperative behavior resulting from the member's special needs.

All plan-initiated disenrollments are subject to approval by EOHHS, after an administrative review of the facts of the case has taken place. EOHHS will determine the disenrollment date as appropriate, based on the results of this review.

F. Grievances, Appeals and Hearings

Federal law requires that Medicaid MCOs have a system in place for enrollees that includes a grievance process, an appeal process, and access to an administrative fair hearing through the State Administrative Fair Hearing Process. For in-plan services, RHP members must exhaust the internal MCO Level I and Level II appeals process before requesting an EOHHS hearing. Regulations governing the appeals process for out-of-plan services are found in MCAR, Section 0110.

- (1) **Types of Appeals** – The plan must maintain internal policies and procedures to conform to state reporting policies, and implement a process for logging appeals. Appeals filed with a managed care plan fall into three (3) categories:
- (a) **Medical Emergency.** An MCO must decide the appeal within seventy-two (72) hours when a treating provider, such as a doctor who takes care of the member, determines the care to be an emergency and all necessary information has been received by the MCO.
 - (b) **Non-Emergency Medical Care.** The two levels of a non-emergency medical care appeal are as follows:
 - For the initial level of appeal, the MCO must decide the appeal within fifteen (15) days from the date that all necessary information is dated as received by the MCO. If the initial decision is adverse to the member, then the MCO must offer the second level of appeal.
 - For the second level of appeal, the MCO must make a decision within fifteen (15) days of the date that all necessary information is dated as received by the MCO.
 - (c) **Non-Medical Care.** If the appeal involves a problem other than medical care, the MCO must resolve the appeal within thirty (30) days of the date that all necessary information is dated as received by the MCO.
 - (d) **Level Three Appeal.** RHP members may also choose to initiate a third level or “external appeal,” in accordance with the Rhode Island Department of Health’s *Rules and Regulations for the Utilization Review of Health Care Services (R23-17.1-UR)*. A member does not have to exhaust the third level appeal before accessing an EOHHS hearing.

Regulations governing the appeals process are found in MCAR, Section 0110.

1475.02 RHP Benefit Package

The IHCC groups participating in RHP under this section 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 managed care plan or through the fee-for-service delivery system if the service is “out-of-plan” – that is, not included in the managed care plan but covered under Medicaid. Fee-for-service benefits may be furnished either by the managed care provider or by any participating provider.

- (1) **Access to Benefits** – Each RHP member selects a primary care physician (PCP) who performs necessary medical care and coordinates referrals to specialty care. The PCP orders treatment determined to be medically necessary in accordance with the health plan’s policies. Prior authorization rules may apply, as required by the Medicaid agency.
- (2) **Delivery of Benefits** – 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.
- (3) **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. 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) **Medicaid Benefits** – The coverage provided through RHP is categorized as follows:

RHP Benefits			
(a) In-Plan		(b) Out-of-Plan	
(01)	Inpatient Hospital Care	(01)	Dental Services
(02)	Outpatient Hospital Services	(02)	Court-ordered Mental Health and Substance Abuse Services Ordered to a Non-network Facility or Provider
(03)	Physician Services	(03)	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS' non-emergency transportation broker.)
(04)	Family Planning Services	(04)	Nursing home Services in Excess of 30 Consecutive Days
(05)	Prescription Drugs	(05)	Opioid Treatment Provider Health Home
(06)	Non-Prescription Drugs	(06)	Residential Services for Beneficiaries with Intellectual and Developmental Disabilities
(07)	Laboratory Services	(07)	Home stabilization services
(08)	Radiology Services	(08)	Preventive services, including: <ul style="list-style-type: none"> • Homemaker • Minor Environmental Modifications • Physical Therapy Evaluation and Services • Respite
(09)	Diagnostic Services		
(10)	Outpatient & Inpatient Mental Health and Substance Use Services		
(11)	Court-ordered Mental Health and Substance Abuse Services – Criminal Court		
(12)	Court-ordered Mental Health and Substance Abuse Treatment – Civil Court		
(13)	Home Health Services		
(14)	Emergency Room Service and Emergency Transportation Services		
(15)	Nursing Home Care and Skilled Nursing Facility Care		
(16)	Services of Other Practitioners		
(17)	Podiatry Services		
(18)	Optometry Services		

RHP Benefits			
(a) In-Plan		(b) Out-of-Plan	
(19)	Oral Health		
(20)	Hospice Services		
(21)	Durable Medical Equipment		
(22)	Group/Education Programs		
(23)	Interpreter Services		
(24)	Transplant Services		
(25)	Adult Day Services		
(26)	HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS and those at High Risk for Acquiring HIV		
(27)	AIDS Medical Case Management		

- (5) **Communities of Care** – The primary goal of Communities of Care (CoC) is to improve access to care and promote member involvement in their care in an effort to decrease non-emergent and avoidable Emergency Department (ED) utilization and associated costs. The target population for CoC is Medicaid beneficiaries who utilize the ED four (4) or more times during the most recent twelve (12) month period. CoC is available to RHP-eligible beneficiaries. A full description of the CoC is located in MCAR, Section 1314.

1475.03 to 1475.24 Reserved

1475.25 Integrated Care Initiative (ICI)

A. Authority and Overview

In accordance with R.I.G.L. 40-8.13, the State’s Section Waiver 1115 Demonstration and other federal waivers and authorities, EOHHS has developed a two-phase strategy for implementing ICI that uses various contractual arrangements to expand access to comprehensive care management and services.

- (1) **Phase I** – Efforts focus on integrating Medicaid covered services across the care continuum for beneficiaries who need LTSS and do not have Medicare (MNM), and managing and coordinating the care of certain beneficiaries who are dual eligible for Medicaid and Medicare (MME) unless they opt-out of managed care or are eligible for and choose to enroll in the Program of All Inclusive Care for the Elderly (PACE) in accordance with MCAR, Section 1475.70.
- (2) **Phase II** – Under the authority of a special federal waiver, Phase II provides full integration and management of Medicare and Medicaid covered services for MME beneficiaries. MME beneficiaries have the option to enroll in a service delivery arrangement option that manages and coordinates Medicaid and Medicare covered services in accordance with a three-party contractual agreement involving EOHHS, the federal Centers for Medicare and Medicaid Services (CMS), and the participating managed care organization. Again, MME beneficiaries who meet these requirements may qualify for other service delivery options including enrollment in PACE.

B. EOHHS Responsibilities – Phases I and II

As the single State agency for Medicaid, EOHHS oversees administration of the program and is responsible for ensuring that eligibility determinations and enrollment procedures are conducted in accordance with applicable federal and State laws and regulations. There are both MACC group (MAGI standard) and IHCC group (SSI standard) eligibility pathways that may result in enrollment in the principal ICI Phase I plan – Rhody Health Options – for beneficiaries. Enrollment in PACE is a standing option for eligible beneficiaries. For Phase II, applicants must qualify as an MME in accordance with the applicable provisions set forth herein. Effective July 2016, applicants will be processed for Phase I and II through the RI Bridges eligibility system as summarized below:

- (1) **Eligibility Determinations** –EOHHS or its designee is responsible for determining the eligibility of applicants for Medicaid and Medicaid-funded LTSS, including those who have third party coverage through Medicare. All LTSS applicants must meet financial and clinical criteria related to the need for an institutional level of care set forth in MCAR, Sections 0376 and 1500, respectively. The eligibility duties of EOHHS also include:
 - (a) **Level of Need.** EOHHS applies clinical criteria to determine whether and to what extent the needs of an applicant/beneficiary require the level of care provided in an institutional setting – nursing facility, hospital, intermediate care facility for intellectual disabilities. EOHHS is also responsible for identifying beneficiaries for whom there is unlikely to be an improvement in functional/medical status.
 - (b) **Beneficiary Liability.** EOHHS determines the amount LTSS beneficiaries must pay toward the cost of the care – beneficiary liability – through a process referred to as the post-eligibility treatment of income (PETI). All beneficiaries of Medicaid-funded LTSS are required under the Medicaid State Plan and the State’s Section 1115 waiver to contribute to the cost of the services they receive to the full extent their income and resources allow, irrespective of care setting or service delivery option. Failure to make such payments may result in termination of eligibility for non-cooperation (See MCAR, Section 1500.01 (F)).
 - (c) **Person Centered Planning and Service Arrangements.** In addition to determining eligibility and beneficiary liability for Medicaid LTSS, EOHHS is responsible for engaging beneficiaries in person-centered care planning in which the beneficiary leads an assessment and discussion of his or her needs and goals and information about various care options. This process includes the development of a service plan that corresponds to the beneficiary’s needs and goals and assists beneficiaries and their families in selecting the appropriate service delivery option and making care arrangements.
- (2) **Service Delivery Options and Enrollment** –EOHHS assures that every beneficiary has access to health coverage through the service delivery options provided for in federal and State law that most appropriately meet his or her needs. Once a determination of eligibility has been made, beneficiaries are evaluated for enrollment in managed care versus fee-for service.

1475.26 ICI Phase I – Rhody Health Options (RHO)

A. ICI Phase I Participation Criteria

Medicaid beneficiaries are eligible for participation in Phase I if they are twenty-one (21) years of age or

older as follows:

- (1) **ICI Phase I - Eligible Enrollees: Medicaid No Medicare (MNM)** – This group consists of Medicaid beneficiaries without Medicare who meet the financial and clinical criteria for LTSS. Includes Medicaid beneficiaries who have other forms of third party commercial coverage (e.g., employer, union, TRICARE). MNM beneficiaries in this group are enrolled in a plan offered by an MCO under contract with EOHHS that provides integrated, coordinated health services and supports across the care continuum, including LTSS. Beneficiaries who meet these criteria are eligible to receive Medicaid primary care – acute and subacute services – as well as long-term care through an RHO plan providing they are twenty-one (21) years of age or older and meet the applicable eligibility criteria for LTSS and a specific IHCC group or the MACC group for parents/caretakers.
- (2) **ICI Phase I-eligible Enrollees: Medicare-Medicaid Eligible (MME)** – This group consists of Medicare-Medicaid (MME) beneficiaries who are receiving full Medicaid benefits, are entitled to or enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D. Includes MME and other Community Medicaid IHCC group beneficiaries who do not need LTSS but are excluded from enrollment in RHP under MCAR, Section 1475.01. MME beneficiaries have access to Phase I managed care service delivery options, but only for Medicaid services that are not covered by Medicare. For MME beneficiaries in Phase I, participation in ICI does not affect the scope, amount or duration of their Medicare coverage. EOHHS began Phase I enrollment in November 2013. ICI Phase I eligible MME beneficiaries are as follows:
 - Members of the IHCC groups receiving Community Medicaid, including persons with serious and persistent mental illness, who do not need LTSS;
 - MAGI-eligible adults in the MACC group for parents/caretakers;
 - LTSS recipients residing in institutional or home and community-based settings including those qualifying for the level of care provided in a nursing facility and intermediate care facility for persons with intellectual disabilities (ICF-ID) – e.g., nursing facility, assisted living and I/DD group home residents as well as those residing in their own homes; and
 - Persons with End Stage Renal Disease (ESRD) at the time of enrollment.

MME beneficiaries are entitled to Medicaid State Plan and Section 1115 waiver services that are not covered by Medicare. These Medicaid so-called “wraparound” services for MME beneficiaries are also managed and coordinated through several of the Phase I service delivery options.

- (3) **Excluded Beneficiaries** – Certain Medicaid beneficiaries are excluded from participating in the ICI Phase I as indicated below:

<i>Beneficiaries Excluded from for Phase I</i>
(a) Medicare beneficiaries who are not eligible for full Medicaid benefits, including partial dual eligible beneficiaries who participate in the Medicaid Premium Payment Program as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Beneficiaries (SLMBs), and Qualifying Individuals (QIs)
(b) Dual Eligible beneficiaries who are not qualified to enroll in all segments of Medicare
(c) Medicaid beneficiaries residing in Tavares, Eleanor Slater, or out-of-state hospitals
(d) Beneficiaries who are in hospice on the effective enrollment date. Enrollees who elect hospice care after they are enrolled in Phase I can remain in Phase I

(4) **Exempt Beneficiaries** – The following are exempt from enrollment in managed care, including if otherwise qualified for ICI Phase I:

(a) **Exempt Due to Age.** MNM and MME beneficiaries who are between the ages of nineteen (19) and twenty-one (21) are exempt from mandatory enrollment in RHP and receive all Medicaid health coverage on a fee-for-service basis.

(b) **Medically Needy Eligible, Non-LTSS.** Beneficiaries who are determined eligible as medically needy for Community Medicaid due to excess income and resources are also exempt from enrollment in managed care. Medicaid health coverage for beneficiaries in this category is provided in accordance with the provisions of MCAR, Section 0368.

The exempted and excluded populations receive all Medicaid covered services – including LTSS – on a fee-for-service basis, unless they are otherwise eligible for another Medicaid delivery system.

B. Phase I Service Delivery Options

EOHHS provides the following ICI Phase I delivery options to all Medicaid beneficiaries who meet program participation criteria:

- (1) **Rhody Health Options (RHO)** – RHO is a managed care service delivery system that integrates and manages Medicaid covered services across the care continuum. The State contracts with a managed care organization – Neighborhood Health Plan of RI – to manage and coordinate all Medicaid State Plan and waiver services. For MNM beneficiaries, RHO integrates the full range of Medicaid services. For MME beneficiaries, RHO manages and coordinates the Medicaid wraparound services to which they are entitled, but otherwise has no impact on enrollment in Medicare Parts A and B, Medicare Advantage Plans or Medicare Part D prescription drug coverage.
- (2) **PACE** – PACE is a service delivery option for beneficiaries who have Medicare and/or Medicaid coverage and meet a “high” or “highest” level of need for LTSS in accordance with MCAR, Section 1500. Beneficiaries must be 55 years old or older to participate in this option.
- (3) **Fee-for-service** – Beneficiaries participating in ICI Phase I receive at least some of their Medicaid health coverage on a fee-for-service basis, even if enrolled in RHO – for example, RHO out-of-plan services. Beneficiaries also have the option to obtain all of their Medicaid covered services on a fee-for-service basis.

Community Health Teams provide care coordination and assistance to beneficiaries in this service delivery option who are not eligible for enrollment in managed care. The Community Health Team-Rhode Island (CHT-RI) is a Primary Care Case Management (PCCM) program for adults who have Medicaid coverage. Currently, these Medicaid members do not receive care management and are not enrolled in a health plan. The CHT-RI program is administered by CareLink and provides beneficiaries assistance with:

- Navigating the health care system
- Care management, client advocacy, and health education
- Working with a person’s primary care doctor

- Links to community resources

Participation in CHT-RI is voluntary. A person can disenroll at any time on a monthly basis. The State auto-enrolls eligible beneficiaries, but provides them with the opportunity to opt out in person, by mail or by telephone.

C. Phase I Enrollment

Managed care enrollment is voluntary for MNM and MME beneficiaries. All enrollments into RHO and PACE are prospective in nature. Accordingly, there is no retroactive enrollment into either of these service delivery options. EOHHS is responsible for ensuring beneficiaries have access to the information they need to make reasoned decisions about whether to obtain their Medicaid health coverage through RHO. (Enrollment procedures related to PACE are located at MCAR, Section 1475.70.) The enrollment process proceeds as follows:

- (1) **Auto-assignment and Opt-Out.** EOHHS sends a letter to Phase I Medicaid beneficiaries explaining ICI and providing an auto-assignment into RHO. This communication also provides instruction on how to opt-out to FFS.
- (2) **Decision Timeframe.** Beneficiaries are given a reasonable timeframe of a minimum of thirty (30) days to consider these options and make an enrollment decision.
 - **Beneficiary Action.** If the beneficiary makes an enrollment choice within the specified timeframe, EOHHS initiates enrollment accordingly.
 - **No Action by Beneficiary.** If a beneficiary does not respond within the specified timeframe, enrollment proceeds in accordance with the auto-assignment into RHO, as indicated in the written communication from EOHHS.
- (3) **Opportunity to Change Option.** Once enrolled, beneficiaries may change Medicaid delivery systems on a monthly basis. Any such changes requested are processed and take effect in accordance with the applicable EOHHS enrollment schedule.
- (4) **Auto Re-Assignment after Resumption of Eligibility.** Medicaid beneficiaries who are disenrolled from RHO due to a loss of eligibility are automatically re-enrolled into RHO if they regain eligibility within sixty (60) calendar days. If eligibility is regained more than sixty (60) calendar days after enrollment has elapsed, the process proceeds in accordance with the subpart (3) above.

D. Phase I Disenrollment

- (1) **EOHHS Initiated Disenrollment EOHHS** – Reasons for EOHHS disenrollment from an RHO plan include but are not be limited to:
 - Death;
 - Loss of Medicaid eligibility;
 - Loss of Medicare eligibility (if previously fully dually eligible for Medicare and Medicaid and not receiving LTSS);
 - MNM beneficiary loss of LTSS eligibility;
 - Eligibility error;

- Placement in Eleanor Slater Hospital, Tavares, or out-of-state residential hospital;
- Incarceration;
- Change of state residence;
- Enrollment in PACE;
- Enrollment in the Medicare-Medicaid Plan established under the Integrated Care Program Phase II; and
- Opt-out to FFS.

(2) **Managed Care Entity Member Disenrollment Request** – The RHO plan may request in writing that a member be disenrolled. Such a request must be made on the grounds that the member’s continued enrollment seriously impairs the entity’s capacity to furnish services to either the particular member or other members. EOHHS does not permit disenrollment requests based on:

- An adverse change in the member's health status;
- The member's utilization of medical services; or
- Uncooperative behavior resulting from the member's special needs.

(3) **Disenrollment Review** – All disenrollments are subject to approval by EOHHS. EOHHS determines the disenrollment date, as appropriate. Beneficiaries who are disenrolled receive their Medicaid benefits on a fee-for-service basis.

E. Grievances, Appeals and Hearings

ICI Phase I offers multiple opportunities for Medicaid beneficiaries to contest decisions affecting their health coverage. These avenues for pursuing recourse vary in number and kind by managed care service delivery option. Regulations governing fee-for-service and PACE appeals and appeals for out-of-plan services are located in MCAR, Section 0110.

(1) **Level I and Level II Plan Appeals** – For in-plan services, RHO Members must exhaust the internal managed care entity’s Level I and Level II appeals process before requesting an EOHHS administrative fair hearing. The RHO plan must maintain internal policies and procedures to conform to state reporting policies, and implement a process for logging grievances and appeals. Appeals must be resolved by the RHO managed care entity within specified timeframes depending on the level of the appeals process. These timeframes are related to the date the RHO plan receives the information from all interested parties required to review and resolve the issue in dispute. Internal RHO plan appeals fall into three (3) categories:

(a) **Expedited.** The RHO plan must render a decision within seventy-two (72) hours of the date all necessary information has been received by the managed care entity when a treating provider, such as a licensed physician who takes care of the member, determines the care in dispute is required on an emergency basis.

(b) **Other Medical Care.** There are two levels of non-emergency medical care appeals:

- For the initial level of appeal, the managed care entity must decide the appeal within fifteen (15) days of the date all necessary information is received by the managed care

entity. If the initial decision is adverse to the member, then the RHO plan must offer the second level of appeal.

- For the second level of appeal, the RHO plan must make a decision within fifteen (15) days of the date that all necessary information has been received by the managed care entity.

(c) **Non-Medical Care.** If the grievance involves a problem other than medical care, the RHO plan must make a decision within thirty (30) days of the date all necessary information has been received.

(2) **Level III – External Appeal** – RHO members may also choose to initiate a third level or “external appeal,” in accordance with the Rhode Island Department of Health’s *Rules and Regulations for the Utilization Review of Health Care Services (R23-17.1-UR)*. A member is not required to exhaust the third level appeal before accessing an EOHHS hearing.

1475.27 RHO Benefit Package

RHO provides a comprehensive benefit package. For MME members, Medicare-funded or other third-party benefits, including prescription drug coverage, is continued for MME members while participating in the RHO plan. In such instances, Medicaid is the payer of last resort. The RHO plan is responsible for coordinating all Medicaid-covered services with Medicare-covered services.

- (1) **Access to Benefits** – Each MNM member selects a primary care physician (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The PCP orders treatment determined to be medically necessary in accordance with the health plan’s policies. Prior authorization rules may apply, as required by the Medicaid agency.
- (2) **Delivery of Benefits** – In-plan services are paid for on a capitated basis. Certain Medicaid-covered services are considered “out-of-plan” and are provided on a fee-for service basis. The RHO plan is not responsible for delivering or reimbursing out-of-plan services, but the RHO plan is expected to coordinate in-plan services with out-of-plan services. Out-of-plan services are provided by existing Medicaid-approved providers who are reimbursed directly by Medicaid on a fee-for-service basis.
- (3) **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. 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) **RHO Benefits** – The coverage provided through RHO is categorized as follows:

RHO Benefits			
(a) In-Plan		(b) Out-of-Plan	
(01)	Inpatient Hospital Care	(01)	Dental Services
(02)	Outpatient Hospital Services	(02)	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS’ non-emergency transportation broker.)
(03)	Physical Therapy Evaluation and Services	(03)	Opioid Treatment Provider Health Home

RHO Benefits			
(a) In-Plan		(b) Out-of-Plan	
(04)	Physician Services	(04)	Residential Services for Clients with Intellectual and Developmental Disabilities
(05)	Care Management Services	(05)	Home Stabilization Services
(06)	Family Planning Services		
(07)	Prescription Drugs		
(08)	Non-Prescription Drugs		
(09)	Laboratory Services		
(10)	Radiology Services		
(11)	Diagnostic Services		
(12)	Mental Health and Substance Use Disorder Treatment-Outpatient/Inpatient		
(13)	Home Health Services		
(14)	Home Care Services		
(15)	Emergency Room Service and Emergency Transportation Services		
(16)	Nursing Home Care and Skilled Nursing Facility Care		
(17)	Services of Other Practitioners		
(18)	Podiatry Services		
(19)	Optometry Services		
(20)	Oral Health		
(21)	Hospice Services		
(22)	Crossover Claims		
(23)	Durable Medical Equipment		
(24)	Adult Day Health		
(25)	Nutrition Services		
(26)	Group/Individual Education Programs		
(27)	Interpreter Services		
(28)	Transplant Services		
(29)	HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS and those that are at High Risk for Acquiring HIV		
(30)	AIDS Medical Case Management		
(31)	Court-ordered Mental Health and Substance Abuse Services – Criminal Court		
(32)	Court-Ordered Mental Health and Substance Abuse Treatment – Civil Court		
(33)	Preventive Services, including: <ul style="list-style-type: none"> • Homemaker • Minor Environmental Modifications • Physical Therapy Evaluation and Services • Respite 		
(34)	Long Term Services and Supports, including: <ul style="list-style-type: none"> • Homemaker 		

RHO Benefits	
(a) In-Plan	(b) Out-of-Plan
<ul style="list-style-type: none"> • Environmental Modifications (Home Accessibility Adaptations) • Special Medical Equipment (Minor Assistive Devices) • Meals on Wheels (Home Delivered Meals) • Personal Emergency Response (PERS) • Skilled Nursing Services (LPN Services) • Community Transition Services • Residential Supports • Day Supports • Supported Employment • RItE @ Home (Supported Living Arrangements-Shared Living)* • Private Duty Nursing • Supports for Consumer Direction (Supports Facilitation) • Participant Directed Goods and Services • Financial Management Services (Fiscal Intermediary) • Senior Companion (Adult Companion Services) • Assisted Living • Personal Care Assistance Services • Respite • Rehabilitation Services 	

1475.28 to 1475.39 Reserved

1475.40 ICI Phase II – Medicare-Medicaid Plan (MMP)

A. Phase II Overview

ICI Phase II is a statewide initiative designed to manage and coordinate the full spectrum of both Medicaid and Medicare services for Medicare and Medicaid (MME) adults. All MME members who are participating in Phase II are enrolled in a Medicare-Medicaid Plan (MMP). A three-party agreement involving EOHHS, the MCO operating the MMP, and the federal Centers for Medicare and Medicaid Services (CMS) governs the organization, financing, and delivery of Medicaid and Medicare services to MME beneficiaries who choose to participate.

B. ICI Phase II Participation Criteria

MME beneficiaries are eligible for participation in Phase II if they are age twenty-one (21) and older as follows:

(1) **ICI Phase II MME-only Enrollees** – Medicare-Medicaid beneficiaries who are receiving full Medicaid benefits, are entitled to or enrolled in Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D. Includes MME and other Community Medicaid IHCC group beneficiaries as well as those who need LTSS. Phase II eligible MME beneficiaries are as follows:

- Members of the IHCC groups receiving Community Medicaid, including persons with serious and persistent mental illness, who do not need LTSS;
- MAGI-eligible adults in the MACC group for parents/caretakers;
- LTSS recipients residing in institutional or home and community-based settings including those qualifying for the level of care provided in a nursing facility and intermediate care facility for persons with intellectual disabilities (ICF-ID) – e.g., nursing facility, assisted living and ID group home residents as well as those residing in their own homes; and
- Persons with End Stage Renal Disease (ESRD) at the time of enrollment.

MME beneficiaries are entitled to Medicaid State Plan and Section 1115 waiver services that are not covered by Medicare. These Medicaid so-called “wraparound” services for MME beneficiaries are also managed and coordinated through several of the Phase I service delivery options.

(2) **Excluded Beneficiaries** – Certain Medicaid beneficiaries are excluded from participating in ICI Phase II as indicated below:

<i>Beneficiaries Excluded from ICI Phase II</i>
(a) Medicare beneficiaries who are not eligible for full Medicaid benefits, including partial dual eligible beneficiaries who participate in the Medicaid Premium Payment Program as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Beneficiaries (SLMBs), and Qualifying Individuals (QIs)
(b) Dual Eligible beneficiaries who are not qualified to enroll in all segments of Medicare
(c) Medicaid beneficiaries residing in Tavares, Eleanor Slater, or out-of-state hospitals
(d) Beneficiaries who are in hospice on the effective enrollment date. Enrollees who elect hospice care after they are enrolled in Phase II can remain in Phase II
(e) Beneficiaries who reside out-of-state for six (6) consecutive months or longer
(f) Beneficiaries who are eligible for the Medicaid Buy-In Program for Working People with Disabilities (known as the “The Sherlock Plan” in Rhode Island)

(3) **Exempt Beneficiaries** – The following are exempt from enrollment in managed care, including if otherwise qualified for ICI Phase II:

- (a) **Exempt Due to Age.** MME beneficiaries who are between the ages of nineteen (19) and twenty-one (21) are exempt from enrollment in managed care and receive all Medicaid health coverage on a fee-for-service basis.
- (b) **Medically Needy Eligible, Non-LTSS.** Beneficiaries who are determined eligible as medically needy for Community Medicaid due to excess income and resources are also exempt from the enrollment in managed care. Medicaid health coverage for beneficiaries in

this category is provided in accordance with the provisions of MCAR, Section 0368.

C. Service Delivery Options

Phase II participating beneficiaries receive services through a managed care arrangement operating under contract with EOHHS. Phase II enrollees receive services through a health plan offered by an MCO or PACE. The operations of the MMP are bound by the three-way agreement with EOHHS and CMS to integrate the full range of Medicare and Medicaid services (primary care, acute care, specialty care, behavioral health care, and LTSS) in accordance with a rate structure that includes federal and state funding streams for all MME adults. Accordingly, the MMP must provide accessible, high-quality services and supports focused on optimizing the health and independence of one of the most fragile Medicaid populations. Enrollment in Phase II of ICI is voluntary.

D. Phase II Enrollment Options

Implementation of the ICI Phase II offers MME beneficiaries the opportunity to obtain comprehensive integrated services through a single health plan.

- (1) **Passive or Auto-Enrollment** – Eligible beneficiaries who are enrolled in an RHO plan operated by the same MCO as the MMP will be passively enrolled, or auto-enrolled, in the MMP unless they are *excluded* on the basis of one of the following criteria:
 - The MME beneficiary is enrolled in a Medicare Advantage plan that is not operated by the same MCO as the MMP;
 - The beneficiary has been auto-enrolled by CMS into a Medicare Part D plan in the same calendar year that the MME would qualify for Phase II;
 - The MME is currently enrolled in comprehensive health insurance coverage through a private commercial plan or group health plan provided through an employer, union, or TRICARE; or
 - The beneficiary has affirmatively opted-out of passive enrollment into an MMP or a Medicare Part D plan.
- (2) **Opt-in Enrollment** – MME beneficiaries who are not eligible for passive enrollment will be offered the opportunity to opt-in to an MMP by completing an application in writing or via phone. Individuals enrolled in PACE may elect to enroll and participate in the Demonstration if they choose to disenroll from PACE.

E. Enrollment Information

EOHHS is responsible for ensuring that all MME beneficiaries who meet the criteria to participate in ICI Phase II have access to the information necessary to make a reasoned choice about their coverage options. As indicated in MCAR, Section 1475.25 (B) (1), the person-centered planning process plays a critical role in ensuring that beneficiaries are aware of the full range of service delivery options available to them based on their level of need and personal goals. Accordingly, prospective participants are sent a written communication informing them of the option to enroll in an MMP. Eligible individuals who opt-out of or do not enroll in an MMP have the option to enroll in an RHO plan, PACE if eligible, or receive all Medicaid covered services – including LTSS – on a fee-for-service basis, unless they are otherwise eligible for another Medicaid delivery system.

Communications with MME beneficiaries who qualify to participate in Phase II includes information about each of the following:

- (1) **Enrollment Opt-In and Opt-Out Process** – Participation in an MMP is voluntary. MME beneficiaries eligible for passive enrollment are informed that they may choose to opt out of enrollment in the MMP and are provided with instructions on how to proceed. MME beneficiaries eligible for passive enrollment who opt-out revert to RHO and may choose any of the alternative service delivery options for which they may qualify. Eligible beneficiaries who are not passively enrolled are provided with instructions on how to enroll in an MMP.
- (2) **Decision Timeframe** – Eligible beneficiaries may enroll in an operational MMP at any time up until six (6) months prior to the end of ICI Phase II. Information is provided about enrollment decision time-frames as follows:
 - (a) **Passive Enrollment.** Beneficiaries eligible for passive enrollment into the MMP are sent a first notification that they will be passively enrolled between sixty (60) and ninety (90) days prior to the effective date of enrollment; a second reminder notification is sent to the beneficiary at least thirty (30) days prior to the effective date of enrollment. If the beneficiary makes an enrollment choice within the specified timeframe, EOHHS initiates enrollment accordingly. If a beneficiary does not respond within the specified timeframe, enrollment in the Medicare-Medicaid plan proceeds in accordance with the terms specified in the initial communication from EOHHS.
 - (b) **Opt-in Enrollment.** MME beneficiaries who are eligible for Phase II but are not passively enrolled are sent a notification that they have the option to enroll in an MMP. Opt-in enrollment requests received through the 10th day of the month will take effect on the first day of the following calendar month. Opt-in enrollment requests received on the 11th day of the month or later will take effect on the first day of the second month after the request was submitted.
- (3) **Opportunity to Change** – Beneficiaries who are being passively enrolled or who opt-in to an MMP may cancel their enrollment any time prior to their effective enrollment date. Once enrolled, beneficiaries may change service delivery options on a monthly basis at any time, but enrollment in the MMP will continue through the end of the month. The requested change will be effective on the first day of the following month. Beneficiaries who cancel enrollment into or voluntarily disenroll from an MMP will be enrolled in RHO, effective the first day of the following month. Once enrolled in RHO, beneficiaries can their change service delivery option according to the disenrollment processes for RHO.
- (4) **Auto Re-Assignment after Resumption of Eligibility** – MME beneficiaries who are disenrolled from an MMP due to a loss of eligibility are eligible for re-enrollment in the plan if eligibility is reinstated and they otherwise meet the requirements for enrollment. Beneficiaries eligible for re-enrollment will be passively enrolled if they meet the requirements for passive enrollment. Otherwise, they will be offered opt-in enrollment.
- (5) **PACE** – PACE is a service delivery option in ICI Phase II for beneficiaries who have Medicare and/or Medicaid coverage and meet a “high” or “highest” level of need for LTSS in accordance with MCAR, Section 1500. Beneficiaries must be 55 years old or older to participate in this option.

F. MMP Member Disenrollment

- (1) **EOHHS Initiated Disenrollment** – Reasons for EOHHS disenrollment from an MMP include but are not limited to:
 - Death;

- No longer eligible for Medicaid;
- Loss of Medicare Part A and/or Part B;
- Enrollment into a Medicare Advantage (Part C) plan or Medicare Part D prescription drug plan;
- Eligibility error;
- Placement in Eleanor Slater Hospital, Tavares, or out-of-state residential hospital;
- Incarceration;
- Changed state of residence;
- Enrollment in PACE; and
- Opt-out to fee-for-service.

Beneficiaries who are involuntarily disenrolled because of incarceration are provided Medicaid coverage on a fee-for-service basis. Beneficiaries who are involuntarily disenrolled for any other reason are enrolled in RHO, pending a review of Medicaid eligibility criteria. Once enrolled in RHO, beneficiaries can their change service delivery option according to the disenrollment processes for RHO.

- (2) **Medicare-Medicaid Plan Disenrollment Request** – The Medicare-Medicaid plan may make a written request to EOHHS and CMS asking that a particular member be disenrolled. Any such request is only considered by EOHHS and CMS when made on the grounds that the member’s continued enrollment seriously impairs the entity’s capacity to furnish services to either the particular member or other members. EOHHS and CMS do not permit disenrollment requests based on:

- An adverse change in the member's health status;
- The member's utilization of medical services; or
- Uncooperative behavior resulting from the member's special needs.

Beneficiaries who are involuntarily disenrolled based on a written request by the MMP receive their Medicaid benefits on a fee-for-service basis.

- (3) **Disenrollment Review** – All disenrollments are subject to approval by EOHHS and CMS. EOHHS and CMS determine jointly the disenrollment date as appropriate.

G. Grievances, Appeals and Hearings

MMP members have multiple avenues for contesting decisions that affect their health coverage, including EOHHS and CMS administrative fair hearings. The process is as follows:

- (1) **MMP Grievances** – Grievances directed toward the MMP may be internal or external.
- (a) **Internal or plan level grievances.** MMP members, or their authorized representatives, can file a grievance with the MCO or a participating provider at any time by calling or writing the MCO or the provider. The MCO must require providers to forward grievances to the MCO. If the MMP member is requesting remedial action related to a Medicare issue, the member must file the grievance with the MCO or the provider no later than ninety (90) days after the event or incident triggering the incident. The MCO must respond, orally or in writing, to an internal grievance within thirty (30) days after the MCO receives the

grievance. The MCO must respond, orally or in writing, within twenty-four (24) hours whenever the MCO extends the timeframe for a decision or refuses to grant a request for an expedited grievance.

- (b) **External.** MMP members, or their authorized representatives, can file a grievance by contacting 1-800-MEDICARE or EOHHS. Any grievance filed with EOHHS will be reviewed by a joint EOHHS-CMS contract oversight team and be made available to the MCO.
- (2) **MMP Appeals** – The process for handling appeals varies depending on whether the beneficiary is disputing an action related to Medicaid or Medicare coverage. For services covered under Medicare Part D, MMP members must follow the appeals process established by CMS in Subparts M and U of 42 C.F.R. Part 423. For services covered by Medicare Part A, Medicare Part B, and/or Medicaid in-plan services, MMP members must complete at least one level of internal appeal before requesting an external review. Regulations governing the appeals process for Medicaid out-of-plan services are found in MCAR, Section 0110. The process for filing subsequent appeals after the first level internal appeal is as follows:
- (a) **Services covered by Medicare Part A and/or B.** Subsequent appeals after the first level internal appeal for traditional Medicare A and B services that are not fully in favor of the Enrollee will be automatically forwarded to the Medicare Independent Review Entity (IRE) by the MMP.
 - (b) **Services covered by Medicaid only.** The MMP must offer a second level internal appeal to MMP members for services covered by Medicaid only, if the first level internal appeal is not fully in favor of the member. Subsequent appeals for services covered by Medicaid only (including, but not limited to, LTSS and behavioral health) may be made to the EOHHS Hearing Office and/or to the Rhode Island External Review Entity per State regulations R23-17.12-1-UR after the second plan-level Appeal has been completed. If an appeal is filed with both the Rhode Island External Review Entity and the EOHHS Hearing Office, the MCO will be bound by any determination in favor of the member that is closest to the relief requested by the member. Appeals related to drugs excluded from Medicare Part D that are covered by Medicaid must be filed with the MMP accordance with MCAR, Sections 1311 and 0110 and the requirements contained herein.
 - (c) **Services covered by both Medicare and Medicaid.** After the first level internal appeal, appeals for services for which Medicare and Medicaid overlap (including, but not limited to, home health, durable medical equipment, and skilled therapies, but excluding Part D) will be auto-forwarded to the IRE by the MMP. The MCO must offer a second level internal appeal to members for services for which Medicare and Medicaid overlap if the first level internal appeal is not fully in favor of the member.

After the second plan-level appeal for Medicare and Medicaid overlapping services, a member may file a request for a hearing with the EOHHS Hearing Office. After the second plan-level appeal for Medicare and Medicaid overlap services, a member may also file a request for a hearing with the Rhode Island External Review Entity per State regulations R23-17.12-1-UR. If an appeal is filed with both the IRE and either the Rhode Island External Review Entity or the EOHHS Hearing Office, the MCO will be bound by any determination in favor of the member that is closest to the relief requested by the member.

(3) Internal appeals timeframes.

- (a) **First Level.** An MMP member must file a first-level internal appeal with the plan within ninety (90) calendar days following the date of the notice of adverse action that generates the appeal.
- (b) **Standard appeals.** For first-level internal appeals, the MMP must render a decision within thirty (30) calendar days of the date that the appeal request has been received by the managed care entity. For second-level internal appeals, the MMP must render a decision within fifteen (15) calendar days of the date that the appeal request has been received by the managed care entity. The MMP can extend the deadline for a decision by up to fourteen (14) days if requested by the beneficiary or if the delay is in the beneficiary’s best interest.
- (c) **Expedited appeals.** For first and second-level internal appeals, the MMP must render a decision within seventy-two (72) hours of the date that the appeal request has been received by the managed care entity when either the MMP or the member’s provider determines that standard appeal resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. The MMP can extend the deadline for a decision by up to fourteen (14) days if requested by the beneficiary or if the delay is in the beneficiary’s best interest.

1475.41 MMP Benefit Package

The MMP provides a comprehensive benefit package to members that includes a full continuum of Medicare and Medicaid services as follows:

- (1) **Medicare** – Medicare Parts A, B, and D-funded medically necessary services.
- (2) **Medicaid Services** – The standard of "medical necessity" is used as the basis for determining whether access to a Medicaid covered services is required and appropriate. 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. Medicaid services may be in-plan or out-of-plan. In-plan services are paid for on a capitated basis. Certain Medicaid-covered services are considered “out-of-plan” and are provided on a fee-for service basis. The MMP is not responsible for delivering or reimbursing out-of-plan services, but is expected to coordinate in-plan services with out-of-plan services. Out-of-plan services are provided by existing Medicaid-approved providers who are reimbursed directly by Medicaid on a fee-for-service basis. The Medicaid coverage provided through the MMP is categorized as follows:

<i>MMP Medicaid Benefits</i>			
<i>(a) In-Plan</i>		<i>(b) Out-of-Plan</i>	
(01)	Inpatient Hospital Care	(01)	Dental Services
(02)	Outpatient Hospital Services	(02)	Non-Emergency Transportation Services (The health plan is required to coordinate with EOHHS’ non-emergency transportation broker.)
(03)	Physical Therapy Evaluation and Services	(03)	Opioid Treatment Provider Health Home
(04)	Physician Services	(04)	Residential Services for Clients with Intellectual and Developmental Disabilities
(05)	Care Management Services	(05)	Home Stabilization Services

MMP Medicaid Benefits	
(a) In-Plan	(b) Out-of-Plan
(06)	Family Planning Services
(07)	Prescription Drugs
(08)	Non-Prescription Drugs
(09)	Laboratory Services
(10)	Radiology Services
(11)	Diagnostic Services
(12)	Mental Health and Substance Use Disorder Treatment-Outpatient/Inpatient
(13)	Home Health Services
(14)	Home Care Services
(15)	Emergency Room Service and Emergency Transportation Services
(16)	Nursing Home Care and Skilled Nursing Facility Care
(17)	Services of Other Practitioners
(18)	Podiatry Services
(19)	Optometry Services
(20)	Oral Health
(21)	Hospice Services
(22)	Crossover Claims
(23)	Durable Medical Equipment
(24)	Adult Day Health
(25)	Nutrition Services
(26)	Group/Individual Education Programs
(27)	Interpreter Services
(28)	Transplant Services
(29)	HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS and those that are at High Risk for Acquiring HIV
(30)	AIDS Medical Case Management
(31)	Court-ordered Mental Health and Substance Abuse Services – Criminal Court
(32)	Court-ordered Mental Health and Substance Abuse Treatment – Civil Court
(33)	Preventive Services, including: <ul style="list-style-type: none"> • Homemaker • Minor Environmental Modifications • Physical Therapy Evaluation and Services • Respite
(34)	Long Term Services and Supports, including: <ul style="list-style-type: none"> • Homemaker • Environmental Modifications (Home Accessibility Adaptations)

MMP Medicaid Benefits	
(a) In-Plan	(b) Out-of-Plan
<ul style="list-style-type: none"> • Special Medical Equipment (Minor Assistive Devices) • Meals on Wheels (Home Delivered Meals) • Personal Emergency Response (PERS) • Skilled Nursing Services (LPN Services) • Community Transition Services • Residential Supports • Day Supports • Supported Employment • RItE @ Home (Supported Living Arrangements-Shared Living)* • Private Duty Nursing • Supports for Consumer Direction (Supports Facilitation) • Participant Directed Goods and Services • Financial Management Services (Fiscal Intermediary) • Senior Companion (Adult Companion Services) • Assisted Living • Personal Care Assistance Services • Respite • Rehabilitation Services 	

1475.42 to 1475.49 Reserved

1475.50 Prescriptions: Generic Policy

For RHP, RHO, and MMP enrolled members, Medicaid prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by the Medicaid agency, 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.

1475.51 Home Stabilization Services Policy

Home stabilization services are available for beneficiaries eligible for enrollment in RHP, RHO, or an MMP as follows:

A. No LTSS Eligibility

Home stabilization services are available for RHP, RHO, and MMP-eligible beneficiaries who are homeless or at-risk for homelessness or transitioning to the community from institutional settings *and do not qualify for such services through any other federally-funded program administered by the State*. Home stabilization services encompass a broad range of time limited tenancy support services assisting with home find, tenancy and lease compliance, living and household management, entitlement assistance and financial counseling to health and wellness. To qualify for home stabilization services, EOHHS or the agency's authorized representative must determine that beneficiaries meet the following criteria:

- (a) Beneficiary is considered homeless or at-risk of homelessness according to the HUD Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009;
- (b) Beneficiary has history of homelessness as defined by HUD Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009; or
- (c) Ability of the beneficiary to retain current housing situation is jeopardized because non-payment of rent, unsafe living conditions, or repeated episodes of conflict in the housing community as substantiated by a housing or licensed health care provider; and
- (d) Beneficiary is not receiving Medicaid-funded home stabilization services through a program administered by the State such as the Assertive Community Treatment (ACT) team operating under the auspices of the department of behavioral healthcare, developmental disabilities and hospitals.

B. LTSS Eligible

Access to home stabilization services for LTSS beneficiaries is provided in accordance with the applicable provisions set forth in MCAR, Section 1500, related to available services and supports.

1475.52 Non-Emergency Transportation 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, non-

emergency transportation for the Medicaid enrollee may be arranged for by EOHHS, or its agent, in accordance with the provisions established in MCAR, Section 1360.

1475.53 Interpretation Services Policy

EOHHS will notify the health plan when it knows of members who do not speak English as a primary language who have either selected or been assigned to the plan. If more than fifty (50) members speak a single language, the RHP or RHO health plan must make available general written materials, such as its member handbook, in that language. If more than five percent (5%) or fifty (50) members, whichever is less, speak a single language, the MMP must make available general written materials, such as its member handbook, in that language. Interpreter services are covered for any RHP, RHO, or MMP member who speaks a non-English language as a primary language.

1475.54 Tracking, Follow-up, Outreach

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

1475.55 Mainstreaming/Selective Contracting

The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of RHP, RHO, and MMP. The MCO therefore must ensure that all of its network providers accept its members for treatment. The MCO also shall accept responsibility for ensuring that network providers do not intentionally segregate RHP, RHO, and MMP members in any way from other persons receiving services. MCOs may develop selective contracting arrangements with certain providers for the purpose of cost containment, but shall adhere to the access standards as defined in the MCO contracts.

1475.56 to 1475.69 Reserved

1475.70 Program of All-Inclusive Care for the Elderly (PACE)

A. Overview

In 2005, the Rhode Island General Assembly enacted R.I.G.L. § 40-8.8 authorizing the Medicaid state agency to establish PACE as an optional integrated service delivery option pursuant to § 1905(a)(26) of the Social Security Act [42 U.S.C. § 1396d(a)(26)], as added by § 4802(a)(1) of the Balanced Budget Act of 1997. PACE provides a managed plan of coordinated Medicare and Medicaid covered services from across the care continuum to certain beneficiaries age fifty-five (55) and older. The operations of PACE are bound by a three-way agreement between EOHHS, CMS, and the PACE provider to integrate the full range of Medicare and Medicaid services (primary care, acute care, specialty care, behavioral health care, and LTSS) for PACE participants.

B. EOHHS Responsibilities

EOHHS is responsible for the eligibility and enrollment functions set forth in MCAR, Section 1475.25 (B), establishing PACE provider standards, and oversight and monitoring of all aspects of the PACE program.

C. PACE Provider Responsibilities

The PACE provider is responsible for:

- Point of entry identification;
- Submitting all necessary documentation for initial determinations and reevaluations of a level of need and referral to EOHHS to a RI Bridges LTSS specialist for a determination of financial eligibility;
- Verifying PACE enrollment prior to service delivery;
- Verifying and collecting required beneficiary liability (cost-share amount);
- Providing and coordinating all integrated services;
- Reporting changes to the PACE-eligibility status of participants; and
- Adhering to all PACE provider requirements as outlined in the PACE Program Agreement between EOHHS and CMS, and to all credentialing standards required by EOHHS including data submission.

D. PACE Participation Criteria

To qualify as a Medicaid-eligible PACE participant, an individual must:

- Be fifty-five (55) years of age or older;
- Meet the criteria for a high or the highest need for a nursing facility level of care in accordance with MCAR, Section 1500; and
- Meet all other financial and non-financial requirements for Medicaid LTSS such as, but not limited to, citizenship, residency, resources, income, and transfer of assets.

Medicaid-eligible PACE participants may be, but are not required to be, enrolled in Medicare.

E. PACE Disenrollment

(1) **Reasons for PACE Disenrollment** – Reasons for disenrollment from PACE include but are not limited to:

- Death;
- Loss of Medicaid eligibility;
- Eligibility error;
- Placement in an out-of-state residential hospital;
- Incarceration;
- Change of state residence;
- Loss of functional level of care; and
- Voluntary opt-out to Medicaid FFS.

The PACE provider may also request in writing that a member be disenrolled on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members. In such instances, EOHHS will notify the PACE provider about its decision to approve or disapprove the disenrollment request within fifteen (15) days from the date EOHHS has received all information needed for a decision. Upon EOHHS approval of the disenrollment request, the PACE provider must, within three (3) business days, forward copies of a completed Disenrollment Request Form to EOHHS and to the Medicare enrollment agency (when appropriate). The PACE provider must also send written notification to the member that includes:

- A statement that the PACE provider intends to disenroll the member;
- The reason(s) for the intended disenrollment; and
- A statement about the member's right to challenge the decision to disenroll and how to grieve or appeal such decision.

(2) **Disenrollment Requests Not Allowed.** EOHHS does not permit disenrollment requests based on:

- An adverse change in the member's health status;
- The member's utilization of medical services; or
- Uncooperative behavior resulting from the member's special needs.

(3) **Voluntary Disenrollment** – PACE participants may voluntarily disenroll from PACE at any time. A voluntary disenrollment from PACE will become effective at midnight of the last day of the month in which the disenrollment is requested.

(4) **Disenrollment Process.** Regardless of the reason for disenrollment, EOHHS is responsible for completing all disenrollment actions. Disenrollments requested by the PACE provider on the grounds that the member's continued enrollment seriously impairs the entity's capacity to furnish services to either the particular member or other members are subject to EOHHS approval. Beneficiaries who are disenrolled from PACE but retain Medicaid eligibility will be enrolled in Medicaid fee-for-service and may subsequently choose or be enrolled in an alternative service delivery if they qualify.

(5) **Disenrollment Effective Date.** Regardless of the reason for disenrollment, all disenrollments from PACE will become effective at midnight of the last day of the month in which the disenrollment is requested.

F. Disenrollment Appeal – If the member files a written appeal of the disenrollment within ten (10) days of the decision to disenroll, the disenrollment shall be delayed until the appeal is resolved.

G. Re-enrollment and Transition Out of PACE – All re-enrollments will be treated as new enrollments except when a participant re-enrolls within two months after losing Medicaid eligibility. In this situation, the participant's re-enrollment will not be treated as a new enrollment. The PACE provider shall assist participants whose enrollment ceased for any reason in obtaining necessary transitional care through appropriate referrals, by making medical records available to the participant's new service providers, and (if applicable), by working with EOHHS to reinstate participant's benefits.

1475.71 PACE Benefit Package

CMS and EOHHS approve PACE providers who are responsible for providing the full scope of Medicare (if eligible) and Medicaid State Plan and waiver services, including but not limited to:

- Multidisciplinary assessment and treatment planning;
- Case Management services;
- Personal Care;
- Homemaking;
- Rehabilitation;
- Social Work;
- Transportation;
- Nutritional Counseling;
- Recreational Therapy;
- Minor Home Modifications; and
- Specialized Medical Equipment and Supplies.

The PACE program is voluntary for any eligible person, but if an individual selects this program, he/she must get all medical and support services through PACE. There are no benefits outside of the PACE program.

1475.72 to 1475.79 Reserved

1475.80 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.

4/19/2016



Net Present Value: Integrated Care Initiative Phase II - Medicaid Code of Administrative Rule #1475 Proposed

The net present value (NPV) calculation focuses on the Integrated Care Initiative (ICI) Phase II, which will be implemented in July 2016 and is scheduled to end on December 31, 2020. The other managed care programs described in the proposed rule were previously implemented. For each cost and benefit calculation, the following formula was used:

$$NPV(i, N) = \sum_{t=0}^N \frac{R_t}{(1+i)^t}$$

Where “N” represents the total number of periods, “t” represents the period, and “i” represents the discount rate.

The estimates are based on a series of assumptions outlined in this document. Negative amounts are presented in parentheses and reflect costs to the state. Positive amounts reflect benefits to the state. The net (State general revenue and state non-budgetary) impact of ICI Phase II is estimated to be positive, indicating that ICI Phase II will result in savings to the state and have an overall positive benefit. As a result, the proposed rule should be adopted.

Period	Impact
T ₀	\$3,259,854
T ₁	\$3,799,359
T ₂	\$5,925,939
T ₃	\$2,953,931
T ₄	\$2,722,516
NPV	\$18,661,599

This rule makes provisions related to the **Integrated Care Initiative (ICI) Phase II**, which is designed to integrate Medicare and Medicaid benefits into a single capitated delivery system, known as a Medicare-Medicaid plan for eligible beneficiaries. ICI Phase II is being implemented through a federal demonstration that is scheduled to begin in Rhode Island in summer 2016 and continue through December 31, 2020. ICI Phase II is a partnership between the federal Centers for Medicare and Medicaid Services (CMS), and the Rhode Island Executive Office of Health and Human Services (acting on behalf of the State of Rhode Island), and Neighborhood Health Plan of Rhode Island, the parent organization of the Medicare-Medicaid plan. ICI Phase II is governed by a three-way contract between the three entities. Eligible Medicare-Medicaid beneficiaries will be offered enrollment in the new Medicare-Medicaid plan beginning in summer 2016.

The goals of ICI Phase II are to: 1. improve the health, well-being, and health care of Medicare-Medicaid beneficiaries in Rhode Island; and 2. reduce overall health care costs by redesigning the care delivery system. **To achieve these goals, the Medicare-Medicaid plan** will offer a comprehensive set of integrated medical, mental health, ancillary, long-term services and supports (LTSS), and community support services (e.g., interpreter services) that are accessible, high-quality, and well-coordinated and managed. Medicare and Medicaid will contribute to the

total capitation payment, as well as risk and gain share payments, for Neighborhood Health Plan of Rhode Island. The eligible population is comprised of non-elderly adults with disabilities and elderly adults, who tend to be high utilizers of hospital, LTSS, and other high cost services.

Phase II is expected to have a number of other benefits for enrollees, their providers, and the state, including (but not limited to):

- a single set of integrated benefits, prior authorization, claims, and referral requirements that will be easier for enrollees and their providers to navigate;
- increased flexibility for the health plan in administering the Medicaid and Medicare benefits, which will allow the plan to better meet enrollee needs and improve enrollee outcomes by waiving some Medicare and Medicaid rules and requirements (e.g., co-payments for prescription drugs, 3-day hospital stay requirement for the Medicare skilled nursing benefit);
- a robust care delivery model and extensive care management services that are adjusted to the needs, risk level, and preferences of the enrollee and that are intended to proactively identify enrollees at high risk for adverse outcomes, reduce unnecessary use of hospital and institutional care, promote use of home and community-based care, and improve enrollee outcomes; and
- better coordination of Medicare and Medicaid benefits for dual-eligible beneficiaries, which will allow the plan to ensure that beneficiaries are receiving medically necessary services in a timely manner and in the least restrictive setting possible.

Adoption of the rule ensures that this new managed care option may be extended to beneficiaries who have both Medicare and Medicaid.

NPV ANALYSIS

Findings

	Calendar Year	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>
	T	0	1	2	3	4
Costs	General Revenue	(\$585,366)	(\$590,942)	(\$587,475)	(\$604,337)	(\$621,705)
	Infrastructure	(\$55,557)	(\$45,238)	(\$25,400)	(\$25,400)	(\$25,400)
	Operations	(\$529,810)	(\$545,704)	(\$562,075)	(\$578,937)	(\$596,305)
	State Non-Budgetary	(\$1,032,772)	(\$3,383,097)	(\$5,018,215)	(\$10,597,509)	(\$11,761,546)
	Federal Savings on Medicaid capitation rates	(\$202,613)	(\$875,319)	(\$1,126,974)	(\$2,785,879)	(\$2,869,455)
	Federal Savings on Medicare capitation rates	(\$365,262)	(\$1,577,985)	(\$2,031,655)	(\$5,022,251)	(\$5,172,919)
	Nursing Home Industry	(\$464,897)	(\$929,793)	(\$1,859,586)	(\$2,789,379)	(\$3,719,172)
Benefits	General Revenue	\$202,613	\$875,319	\$1,126,974	\$2,785,879	\$2,869,455
	State Non-Budgetary	\$4,675,379	\$7,012,060	\$10,765,545	\$11,643,808	\$12,578,012
	Federal Investment in Infrastructure	\$500,012	\$407,142	\$228,600	\$228,600	\$228,600
	Federal Investment in Operations	\$1,799,810	\$1,853,805	\$1,909,419	\$1,966,701	\$2,025,702
	Medical System	\$0	\$0	\$3,095,263	\$3,135,094	\$3,229,146
	Home- and Community-Based Industry	\$332,069	\$664,138	\$1,328,276	\$1,992,414	\$2,656,552
	Beneficiaries	\$58,506	\$117,012	\$234,025	\$351,037	\$468,049
	Caregivers	\$1,984,981	\$3,969,963	\$3,969,963	\$3,969,963	\$3,969,963
Net Impact	General Revenue	(\$382,753)	\$284,377	\$539,499	\$2,181,542	\$2,247,750
	State Non-Budgetary	\$3,642,607	\$3,628,963	\$5,747,330	\$1,046,299	\$816,466
	Total	\$3,259,854	\$3,913,340	\$6,286,828	\$3,227,840	\$3,064,216
Discount Rate	3%					
Present Value	Total	\$3,259,854	\$3,799,359	\$5,925,939	\$2,953,931	\$2,722,516
Net Present Value (NPV)			\$18,661,599			

Assumptions

- Total eligible beneficiaries in Rhode Island = 30,370
- Estimated number of enrollees = 12,034
- Estimated average enrollment in nursing facility LTSS (2016) = 1,907
- Estimated annual LTSS financing shift to home and community-based settings = +2%
- Impact of program on system waste = -0.9%
- Waste includes failures of care coordination, administrative complexity, overpricing, overtreatment, and fraud and abuse
- Estimated time for program to impact waste in health care system = 2 years
- Average number of caregivers per beneficiary enrolled = 0.25
- Caregiving time saved per caregiver = 10%
- Percent of contribution to the cost of the care saved for beneficiaries who transition from nursing facilities = 50%
- Discount rate: 3% over each period. Most of the initial implementation costs are incurred in 2016 and not 2015. As a result, we do not apply the discount rate to the CY 2015-2016 implementation costs.

Explanation

Costs - General Revenue

Infrastructure

Infrastructure costs reflect systems costs required to operate the program. System costs are matched by CMS at a 90-10 rate, with the State paying for 10% of the costs through general revenue funds and the federal government paying for 90% of the costs. We estimate that the State will spend \$0.2 million in general revenue funds through the end of 2020 on infrastructure for ICI Phase II.

Operations

Operating costs include call center and staffing costs needed to operate the program. Operating costs are primarily shared equally by the State and federal government, but some operating costs are matched at a higher rate, with the federal government paying for a higher share of the costs. We estimate that the State will spend \$2.8 million in general revenue funds through the end of 2020 on operating costs for ICI Phase II.

Costs – State Non-Budgetary

Federal Savings on Medicaid Capitation Rates and Federal Savings on Medicare Capitation Rates

The three-way contract between EOHHS, CMS, and NHPRI includes requirements for the State and CMS to reduce the Medicare and Medicaid capitation rates paid to the plan. This reduction, referred to in the contract as a savings percentage, is 1% in 2016 and 2017,

1.25% in 2018, and 3% in 2019 and 2020 for the Medicare and the Medicaid capitation rates. Application of the savings percentage to Medicare and Medicaid capitation rates will result in a reduction in federal expenditures in Rhode Island and are reflected as a cost to the state that is not reflected in the State budget. The cost to the state of the federal savings on the Medicaid capitation rates is estimated to be \$7.9 million through the end of 2020, while the cost to the state of the federal savings on the Medicare capitation rates is estimated to be \$14.2 million through the end of 2020.

Nursing Home Industry

ICI Phase II is expected to support state efforts to rebalance the long-term care system by increasing the percentage of Medicaid dollars spent on long-term services and supports (LTSS) in home and community-based, as opposed to institutional, settings. We estimate that this program will result in a 2% annual shift in LTSS financing from institutional to home and community-based settings. This will result in a loss of Medicaid revenues to nursing facilities, but we also conservatively estimate that about 30% of the loss will be offset by increased revenue from other payers (e.g., increased supply of nursing facility beds will result in increased revenue for short-stay skilled nursing stays paid by Medicare), reductions in nursing facility costs (e.g., reduced staffing costs by taking empty beds out of service), and new sources of revenue for the facilities (e.g., converting empty nursing facility beds into assisted living beds). We estimate that the cost to the nursing home industry through the end of 2020 will be \$9.8 million.

Benefits – General Revenue

As noted above, the three-way contract between EOHHS, CMS, and NHPRI includes requirements for the State and CMS to reduce the Medicare and Medicaid capitation rates paid to the plan. This reduction is 1% in 2016 and 2017, 1.25% in 2018, and 3% in 2019 and 2020 for the Medicare and the Medicaid capitation rates. As a result, the state will benefit from a \$7.9 million reduction in general revenue spending through the end of 2020 as a result of the reduction in the State portion of the Medicaid capitation payment.

Benefits – State Non-Budgetary

Federal Investment in Infrastructure

Infrastructure costs reflect systems costs required to implement and operate the program. System costs are matched by CMS at a 90-10 rate, with the State paying for 10% of the costs through general revenue funds and the federal government paying for 90% of the costs. As a result, the state will benefit from a \$1.6 million federal investment in infrastructure for this program through the end of 2020.

Federal Investment in Operations

Operating costs include call center and staffing costs needed to implement and operate the program. Operating costs are primarily shared equally by the State and federal government, but some operating costs are matched at a higher rate, with the federal government paying for a higher share of the costs. We anticipate that the state will benefit from a \$9.6 million federal investment in the operating costs of this program through the end of 2020.

Medical System

As noted in the assumptions, we assume that, beginning in 2018, this program will be able to reduce system waste by 0.9%. System waste includes failures of care coordination, administrative complexity, overpricing, overtreatment, and fraud and abuse. As a result, we expect ICI Phase II to provide a positive benefit to the state by reducing system waste by \$9.5 million between 2018 and the end of 2020.

Home and Community-Based Services Industry

As noted above, ICI Phase II is expected to support state efforts to rebalance the long-term care system by increasing the percentage of Medicaid dollars spent on long-term services and supports (LTSS) in home and community-based, as opposed to institutional, settings. We estimate that this program will result in a 2% annual shift in LTSS financing from institutional to home and community-based settings. This will result in an estimated increase of \$7.0 million in revenue for LTSS providers that deliver home and community-based services.

Beneficiaries

In Rhode Island, Medicaid beneficiaries who are receiving long-term services and supports in a nursing facility or in the community are required to contribute to the cost of their care. This shift in LTSS financing from institutional to home and community-based settings will have a financial benefit for beneficiaries who will experience reductions in their contributions to the cost of care as a result of transitioning or being diverted from a nursing facility to a community-based setting. We estimate that beneficiaries will save \$1.2 million through the end of 2020 as a result of reductions in beneficiary contributions to the cost of care.

Caregivers

The additional care management and other supports that people who enroll in this program will receive is expected to benefit family and informal caregivers by reducing the amount of time that they spend caring for beneficiaries. We estimate the economic value of this reduction in unpaid caregiving time to be \$17.9 million through the end of 2020.

Net Impact – General Revenue

The net impact of this program on general revenues is expected to be a savings of \$4.9 million through the end of 2020.

Net Impact – State Non-Budgetary

This program is expected to have a positive net impact to the state on costs and benefits that are not reflected in the State budget. Through the end of 2020, we estimate that this program will result in a net benefit to the state of \$14.9 million on state non-budgetary items.

Net Present Value

After the application of a 3% discount rate, we estimate the total state (general revenue and state non-budgetary) benefit of this program to be \$18.7 million through the end of 2020.