

## **0374 MANAGED CARE PROGRAM OPTIONS FOR ADULTS**

### **0374.05 Legal Authority**

REV: 07/2009

During the 2005 General Assembly session, the Rhode Island legislature authorized the Rhode Island Department of Human Services to design managed care programs for adults who are on Medicaid. Title XIX of the Social Security Act provides the legal authority for the States to administer their Medical Assistance Program. The Rhody Health Partners Program, a managed care organization (MCO) model, operates under the authority of Section 1915(a)(1)(A) of the Social Security Act.

Connect Care Choice, which is a primary care case management (PCCM) model, operates under the Federal authority of a 1932(a) State Plan Amendment. Under the authority of RI General Law Section 40-8.5-1.1, all eligible adult Medicaid beneficiaries are required to enroll in one of the two care management programs: Connect Care Choice or Rhody Health Partners.

### **0374.10 Connect Care Choice Program - Overview**

REV: 07/2009

Connect Care Choice is a statewide Primary Care Case Management Model available to Medicaid eligible individuals who do not have third party coverage such as Medicare, and who choose to use a primary care physician whose practice has met DHS quality and performance certification standards. Nurse care managers working with the physicians and participants will ensure effective health care management and coordination of care for participants who meet a moderate or high risk scores determined by the Department of Human Services. The program participant receives their primary care from a participating physician or physician practice, who provides a Medical Home for this individual to manage their chronic care needs and coordinate all their specialty care needs. Those program participants at moderate or high risk as defined by the Department of Human Services also receive nurse care management services provided either through the physician practice, or directly contracted by DHS.

### **0374.15 Rhody Health Partners - Overview**

REV: 09/2007

Rhody Health Partners is a statewide managed care program for Medicaid eligible adults, which increases access to health care for adults in the Medical Assistance Program. Rhody Health Partners offers a comprehensive set of medical, mental health, ancillary and community support services (such as interpreter services) that are accessible, high quality and focused on primary care, specialty care and chronic care management.

Beneficiaries receiving Medicaid through the Rhody Health Partners option are enrolled in a managed care organization (MCO), which uses a primary care provider to coordinate all medically necessary health care services through an organized delivery system. The Department of Human Services (DHS) contracts with MCOs to provide these health services to members.

### **0374.20 Program Eligibility for Rhody Health Partners and**

REV: 07/2009

#### **Connect Care Choice**

Rhody Health Partners and the Connect Care Choice Program are available for select

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populations who are:

- 1 Not covered by other third-party health insurance (including Medicare);
- 2 Residents of Rhode Island;
- 3 Individuals not residing in an institutional facility;
- 4 Age twenty-one (21) and older; and,
- 5 Categorically eligible for Medicaid and medically needy.

### **0374.25 Program Enrollment**

REV: 09/2007

All enrollments into either the Connect Care Choice or Rhody Health Partners Programs are always prospective in nature.

There will be no retroactive enrollment into either the Connect Care Choice or the Rhody Health Partners' MCO.

### **0374.30 Enrollment Process**

REV: 07/2009

All Medical Assistance beneficiaries who meet the criteria within either Connect Care Choice or Rhody Health Partners Programs will receive written communications from DHS that will explain the options to the beneficiary. A reasonable timeframe will be allowed for the beneficiary to make a decision regarding these options. The beneficiary will be enrolled into a participating Rhody Health Partners MCO or the Connect Care Choice program as the beneficiary has indicated. If a beneficiary does not respond within the timeframe the individual will be enrolled in either Rhody Health Partners or Connect Care Choice Program, with the option to change programs during the first ninety (90) days.

### **0374.35 Selection of a Managed Care Option**

REV: 07/2009

The Connect Care Choice and Rhody Health Partners Programs are mandatory programs. Medical Assistance beneficiaries are required to remain enrolled in one of these programs, but are authorized to transfer from one program to the other once a year during open enrollment.

### **0374.40 Automatic Re-Assignment after Resumption of Eligibility**

REV:09/2007

Medicaid members who are disenrolled from Connect Care Choice or Rhody HealthPartners due to a loss of eligibility are automatically re-enrolled, or assigned, into the Connect Care Choice Program or their MCO plan, should they regain eligibility within sixty (60) calendar days. If more than sixty (60) calendar days have elapsed, the enrollment process will follow the process in accordance with DHS Policy Section 0374.30, Enrollment Process.

### **0374.50 Member Disenrollment by DHS**

REV: 09/2010

Reasons for DHS disenrollment from either the Connect Care Choice or the Rhody Health Partners managed care program participation include but are not limited to:

- 1 Death
- 2 No longer Categorically eligible for Medicaid or medically needy;
- 3 Eligibility error;

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- 4 Loss of program eligibility;
- 5 Placement in a nursing facility for more than thirty (30) consecutive days for Rhody Health Partners, and more than sixty (60) consecutive days for Connect Care Choice;
- 6 Placement in Eleanor Slater Hospital;
- 7 Incarceration
- 8 Moved out-of-state
- 9 The participant obtains third-party health insurance coverage(including Medicare);
- 10 Lack of participation in the program requirements.

### 0374.55 MCO Requested Member Disenrollment

REV: 09/2007

A Rhody Health Partners MCO may request in writing that a member be disenrolled from the MCO because the member's continued enrollment in the Rhody HealthPartners MCO seriously impairs the MCO's ability to furnish services to either the particular member or other members. A Rhody Health Partners MCO may not request disenrollment of a member because of:

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

All disenrollments are subject to approval by DHS, after an administrative review of the facts of the case has taken place.

DHS will determine the disenrollment date as appropriate, based on the results of their review.

### 0374.60 Formal Grievances and Appeals

REV: 09/2010

A. Connect Care Choice participants may submit a written request for a fair hearing before the DHS Hearing Officer within thirty (30) days of the mailing of the notice of adverse action.

B. Rhody Health Partners members must exhaust the internal health plan appeals process before requesting a DHS Fair Hearing.

C. The health plans maintain internal policies and procedures to conform to state reporting policies, and provide a process for logging formal grievances.

D. Appeals filed with a Health Plan fall into three (3) areas:

- 1 **Medical Emergency** - A Health Plan must decide the appeal within two (2)business days 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 Health Plan.
- 2. **Other Medical Care** - There are two levels of a non-emergency medical care appeal.
  - a. For the initial level of appeal, the Health Plan must decide the appeal within fifteen (15) days of all necessary information being received by the Health Plan. If the initial decision is against the member, then the Health Plan must offer the second level of appeal.
  - b. For the second level of appeal, the Health Plan must decide on the grievance within fifteen (15) days of all necessary information being received by the Health Plan.
- 2 **Non-Medical Care** - If the grievance involves a problem other than medical care,

the Health Plan must decide the grievance within thirty (30) days and all necessary information has been received by the Health Plan.

E. Rhody Health Partners members may also choose to initiate a third level or external appeal, per the Department of Health 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 the DHS fair hearing process.

Rhody Health Partners members must exhaust the internal health plan appeals process before requesting a DHS Fair Hearing.

Regulations governing the appeals process are found in Section 0110 of the General Provisions of the DHS Rules.

### **0374.65 Rhody Health Partners Benefits**

REV: 09/2010

The Rhody Health Partners Program will provide a comprehensive set of In-Plan Medicaid State Plan benefits, and other additional covered benefits at the discretion of the Department, including short-term nursing home stays. In addition, the health plan will be responsible for the coordination of in-plan services with the case manager of other service delivery systems outside of the health plan.

It is not the responsibility of the health plan to provide out-of-plan benefits that are not included in the capitated payment.

These services are provided by existing Medicaid-approved providers who are reimbursed directly by Medical Assistance on a fee-for-service basis.

Prescription drugs are part of the comprehensive benefit package. For Members of Rhody Health Partners, prescription benefits shall be for generic drugs. Exception for limited brand coverage for certain therapeutic classes shall be granted if approved by the Department of Human Services (DHS), or the Managed Care Organizations acting in compliance with their contractual agreements with DHS, and in accordance with the criteria described below.

For purposes of approving exceptions to generic-first drug coverage for Medical Assistance recipients, DHS will determine certain Allowed Brand Name Therapeutic Classes / Single Agents drugs. DHS will consider the following characteristics of the drug and the clinical conditions under which it is prescribed for purposes of exceptions to generic-first.

Review criteria for approval of exceptions to generic-first will include:

- 1 Availability of suitable within-class generic substitutes or out-of-class alternatives.
- 2 Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.
- 3 Relative disruptions in care that may be brought on by changing treatment from one drug to another.
- 4 Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.
- 5 Relative clinical advantages and disadvantages of drugs within a therapeutic class.
- 6 Cost differentials between brand and generic alternatives.
- 7 Drugs that are require under Federal and State regulations.

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

### **0374.70 Mainstreaming / Selective Contracting**

REV: 09/2010

The mainstreaming of Medical Assistance beneficiaries into the broader health delivery system is an important objective of the Rhody Health Partners Program. The health plan therefore must ensure that all of its network providers accept Rhody Health Partners members for treatment.

The health plan also must accept responsibility for ensuring that network providers do not intentionally segregate Rhody Health Partners members in any way from other persons receiving services.

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

### **0374.75 Communities of Care**

REV: 04/2012

- A. 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.
- B. The target population for CoC are Medicaid recipients who utilize the ED four (4) or more times during the most recent twelve (12) month period. CoC is available to Connect Care Choice (CCC) and Rhody Health Partners (RHP)eligibles without other health insurance coverage (e.g., commercial, Medicare, etc.). Members will be notified of the requirement to participate in CoC. This notification will include program overview, responsibilities, all applicable appeal rights and duration of services. The DHS reserves the right to make exceptions to CoC participation when clinically appropriate. CoC enrollees in Rhody Health Partners who meet established criteria may have access to a limited set of complementary alternative pain management services for the treatment of chronic pain. The complementary alternative services may include limited: Chiropractic care, Acupuncture and Therapeutic Massage in accordance with CMS authority.
- C. CoC will consist of the following core components:
  - 1 Health Service Utilization Profile
  - 2. Identification for and Assignment to Restricted Provider Network (i.e. "Lock-In) or Select Provider Referral
  - 2 Member Outreach and Engagement
  - 3 Assessment for Care Management and/or Peer Navigator
  - 4 Development and Implementation of Personal Incentive/Reward Plan

#### **0374.75.05 Health Service Utilization Profile**

REV: 09/2010

The Department of Human Services (DHS) or its contracted Managed Care Organization(MCO) will create a health service utilization profile for each CoC member based on the services used and determine whether the member is eligible for the Restricted Provider Network or the Select Provider Referral.

## **0374.75.10 Identification for Restricted Provider Network**

REV: 09/2010

CoC members who demonstrate one or more of the following utilization patterns/practices within a consecutive 180-day period will be enrolled in the Restricted Provider network of CoC:

- 1 ED visits with three (3) or more different Emergency Departments in a consecutive 180-day period
- 2 Utilization of four (4) or more different PCP's in a consecutive 180-day period
- 3 Utilization of three (3) or more different Behavioral Health Providers in a consecutive 180-day period
- 4 Prescriptions at six (6) or more different pharmacies in a consecutive 180-day period
- 5 Received controlled substances from four (4) or more different providers in a consecutive 180-day period
- 6 A medical billing history during past 180 days that suggests a possible pattern of inappropriate use of medical resources (e.g. conflicting healthcare services, drugs, or supplies suggesting a pattern of risk).
- 7 Other relevant patterns that emerge during the utilization profile

### **0374.75.10.05 Assignment to Restricted Provider Network**

REV: 09/2010

- A. CoC members selected for the Restricted Provider Network (lock-in) shall select the following providers:
  - 1 One PCP
  - 2 One Pharmacy
  - 3 One Narcotic Prescriber and/or Psychiatric Medication Prescriber (as appropriate based on Health Utilization Profile and case review)
  - 4 One or more mental health and/or substance abuse providers, as appropriate.
- B. CoC members identified for the restricted provider network (lock-in) shall only receive their primary care, narcotic prescription care, pharmacy and behavioral health care from the single provider selected by the member for each of the four provider types noted above.
- C. A member may be exempt from assignment to the Restricted Network when clinically appropriate as determined by DHS or its MCO Medical Director based on further review of the member's health service utilization profile.
- D. Members will be notified of their right to appeal enrollment in the Restricted Provider Network (Lock-In).

### **0374.75.15 Select Provider Referral**

REV: 09/2010

CoC members eligible for the Select Provider Network are those who have a complex medical condition or chronic disease and are not assigned to a Restricted Provider Network (lock-in). CoC members who use multiple providers and have one or more complex medical conditions and chronic diseases (e.g. diabetes, chronic obstructive pulmonary disorder, heart failure, asthma, generalized anxiety disorders, depression) shall be referred to the Select Provider Network. The Select Provider Network shall contain providers who have experience serving the elderly, disabled adults, and those with chronic diseases and multiple complex medical conditions.

## **0374.75.20 Member Outreach and Engagement**

REV: 09/2010

DHS or its contracted MCO shall conduct outreach to eligible CoC member to identify reasons why the recipients opts to utilize the Emergency Department for anon-emergent condition, and how that utilization can be avoided in the future. This includes both avoidance of unnecessary ED utilization and improved connections with care providers to help avoid acute episodes and improve management of chronic conditions. During outreach, DHS or its contracted MCO shall review the CoC program and the member's rights and responsibilities. This includes explanation of the restricted provider network or the select provider referral and the associated appeal rights.

## **0374.75.25 Care Management/Peer Navigator**

REV: 09/2010

Recipients identified for enrollment in CoC shall be assigned a care manager who will assist the client in developing an individualized care plan. CoC members maybe referred to a peer navigator. The role of the peer navigator is to assist the CoC member in reducing barriers to care, to access medical and non-medical resources and to assist the member throughout the care coordination and treatment process.

## **0374.75.30 Development and Implementation of Personal Rewards/Incentive Plan**

REV: 09/2010

Individualized Incentive Plans will be developed for each CoC member consistent with the individual's Care Plan in order to reward specific behaviors and achievements consistent with the CoC Program. The Incentive Plans will be developed by the member's Care Manager and/or Peer Navigator, in conjunction with the member. Members shall be able to select their incentives and rewards, based on a prescribed menu of options, to assure meaningfulness to the reward program. Examples of possible incentives or rewards include gift cards, digital thermometers or recognition events.

## **0374.75.35 Completion of CoC Program Enrollment**

REV: 09/2010

Completion of participation in CoC will occur when:

- 1 care plan objectives are achieved;
- 2 loss of Medicaid eligibility; or
- 3 after a minimum of 12-months in the CoC program.