

**STATE OF RHODE ISLAND  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**PUBLIC NOTICE OF PROPOSED RULE-MAKING**

In accordance Rhode Island General Laws (RIGL) 42-35, notice is hereby given that the Executive Office of Health and Human Services proposes to amend the following OHHS rule:

**Community Supported Living Arrangement and  
Integrated Care Program  
Medicare and Medicaid Eligible and Medicaid-Only Eligibles**

This proposed rule-making supports the mission of the Integrated Care Program to transform the delivery system through purchasing person-centered, comprehensive, coordinated, quality health care and support services that promote and enhance the ability of Medicaid-only and Medicaid/Medicare eligible (MME) recipients to maintain a high quality of life and live independently in the community. Care management is a critical component of this strategy. The adoption of this proposed rule will build upon, improve and integrate with current Care Management programs to better meet the needs of the target population. Care should be less fragmented and more person-centered; care managers should strive to better communicate across settings and providers; and members should have greater involvement in their care management.

The Affordable Care Act provides the states an opportunity to improve the coordination of services for consumers through managed care and primary care case management arrangements. Beginning July 1, 2013, EOHHS will enroll all Medicaid members, including Medicare and Medicaid eligibles (MMEs) into a managed care organization (MCO) or a primary care case management program (PCCM). These members will receive a notice from EOHHS explaining the changes and informing them of their ability to choose between an MCO or PCCM through which all of their Medicaid covered services, including long-term services and supports (LTSS), will be coordinated and reimbursed. LTSS includes nursing home care as well as home and community-based supports that allow members to live independently in the community. Medicare services will continue to be administered by the Medicare program in calendar year 2013. Members will be asked to choose one of these options within thirty days of receiving their notice. Members who do not make a choice will be auto-enrolled into one of these two programs, however, they will have the ability to switch between programs.

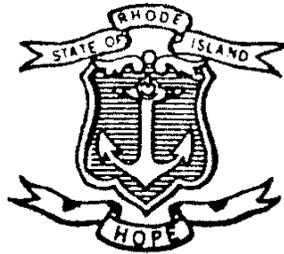
In the development of this rule, consideration was given to the following: (1) alternative approaches; and (2) overlap or duplication with other statutory and regulatory provisions. No alternative approach or duplication or overlap was identified based upon available information.

This proposed rule is accessible through the RI Secretary of State's Proposed Rules and Regulations Database Search (<http://www.sec.state.ri.us/ProposedRules/>), on the OHHS website ([www.ohhs.ri.gov](http://www.ohhs.ri.gov)) or available in hard copy upon request (401 462- 2018). Interested persons should submit data, views or written comments by Wednesday, June 5<sup>th</sup>, 2013 to Kimberly Merolla-Brito, Office of Policy Development, Department of Human Services FL # 1, Louis Pasteur Building, 57 Howard Avenue, Cranston, RI 02920, [KMerollaBrito@ohhs.ri.gov](mailto:KMerollaBrito@ohhs.ri.gov).

In Accordance with RIGL 42-35-3, an oral hearing will be granted if requested by twenty-five (25) persons, by an agency or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within thirty (30) days of this notice.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief or handicap.

Rhode Island  
Executive Office of Health  
and Department of Human Services



**Community Supported Living Arrangement and  
Integrated Care Program**

July 1, 2013

**Rhode Island Executive Office of Health and Human Services**

**Community Supported Living Arrangement and  
Integrated Care Program  
Medicare and Medicaid Eligible and Medicaid-Only Eligibles**

**Rules and Regulations**

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**Rhode Island Executive Office of Health and Human Services**

**Community Supported Living Arrangement and  
Integrated Care Program  
Medicare and Medicaid Eligible and Medicaid-Only Eligibles**

**0374 MANAGED CARE PROGRAM OPTIONS FOR ADULTS**

**0374.05 Legal Authority**

During the 2005 General Assembly session, the Rhode Island legislature authorized the Rhode Island Medicaid Agency 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 members 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**

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 EOHHS quality and performance certification standards. Nurse care managers working with the physicians and members will ensure effective health care management and coordination of care for members who meet a moderate or high risk score as determined by the EOHHS. The program member 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 members at moderate or high risk as defined by the EOHHS also receive nurse care management services provided either through the physician practice, or directly contracted by EOHHS.

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

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.

Members 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 EOHHS contracts with MCOs to provide these health services to members.

### **0374.20 Prog Elig for Rhody Patners + Connect Care**

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

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**

All Medical Assistance members who meet the criteria within either Connect Care Choice or Rhody Health Partners Programs will receive written communications from EOHHS that will explain the options to the beneficiary. A reasonable timeframe will be allowed for the member to make a decision regarding these options. The member will be enrolled into a participating Rhody Health Partners MCO or the Connect Care Choice program as the member has indicated. If a member 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**

The Connect Care Choice and Rhody Health Partners Programs are mandatory programs. Medical Assistance members 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 Auto Re-Assignment After Resumption of Elig.**

Medicaid members who are disenrolled from Connect Care Choice or Rhody Health Partners 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 EOHHS Policy Section 0374.30, Enrollment Process.

#### **0374.45 Voluntary Disenrollment by the Member**

Connect Care Choice and Rhody Health Partners members may choose to voluntarily disenroll from either the Connect Care Choice Program or the MCO option at any time. The disenrollment from either program will be effective no later than forty-five (45) calendar days after the date on which the written request is received by EOHHS.

#### **0374.50 Member Disenrollment by EOHHS**

Reasons for EOHHS 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;
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**

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 Health Partners 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:

- 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 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 their review.

### **0374.60 Formal Grievances and Appeals**

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 or 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.

3. 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 thirdlevel 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**

The Rhody Health Partners Program will provide a comprehensive set of In-Plan Medicaid State Plan benefits, 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 EOHHS, or the Managed Care Organizations acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below.

For purposes of approving exceptions to generic-first drug coverage for Medical Assistance recipients, EOHHS will determine certain Allowed Brand Name Therapeutic Classes / Single Agents

drugs. EOHHS 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**

The mainstreaming of Medical Assistance members 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**

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 EOHHS reserves the right to make exceptions to CoC participation when clinically appropriate.

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
3. Member Outreach and Engagement
4. Assessment for Care Management and/or Peer Navigator
5. Development and Implementation of Personal Incentive/Reward Plan

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

The EOHHS 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.

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#### **0374.75.10 Identification for Restricted Provider Ntwrk**

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 health care 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**

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 EOHHS 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**

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**

EOHHS or its contracted MCO shall conduct outreach to eligible CoC member to identify reasons why the recipients opts to utilize the Emergency Department for a non-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, EOHHS 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**

Members identified for enrollment in CoC shall be assigned a care manager who will assist the client in developing an individualized care plan. CoC members may be 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 Dev. and Implementation of Pers. Rew/Inctv.**

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**

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.

### **0375 MANAGED CARE PROGRAM OPTIONS FOR INTEGRATED CARE FOR ADULTS WITH MEDICARE AND MEDICAID**

#### **0375.05 LEGAL AUTHORITY**

By joint resolution pursuant to Rhode Island General Laws relating to the Medicaid Reform Act; Section 3 of Article 16: Integration of Care and Financing for Medicare and Medicaid Beneficiaries, the Executive Office of Health and Human Services (EOHHS), pursuant to RIGL 42-7.2-2(b), is directed to engage in a contractual arrangement for the expansion and integration of care management strategies by July of 2012 for Medicaid-only

beneficiaries and Medicare and Medicaid eligible (MME) members. Title XIX and XXI of the Social Security Act and other applicable laws and waivers provides the legal authority for the States to administer their Medical Assistance Program. The Rhody Health Options 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 *Community Partners* option, 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 *Community Partners* or Rhody Health Options.

## **0375.10 MANAGED CARE PROGRAM OPTIONS FOR INTEGRATED CARE FOR ADULTS WITH MEDICARE AND MEDICAID**

### **0375.10.05 Connect Care Choice *Community Partners* Program - Overview**

Connect Care Choice *Community Partners* (CCCCP) is a Primary Care Case Management (PCCM) model managed care program for Medicaid eligible adults. Under the CCCCCP model, the strengths of Connect Care Choice (CCC) are combined with an enhanced capacity in care management and service integration across all service categories: primary care, acute care, specialty care, behavioral health and long-term care services and supports. This preserves the core person-centered medical home aspect of the CCC and builds on the established chronic care model of best practices. For members needing LTSS, the LTSS care management and transition services would be performed by the state staff within the EOHHS Office of Community Programs (OCP) or Division of Elderly Affairs (DEA). To address the needs for greater integration of primary care, acute care, specialty care, behavioral health and long-term care services and for high touch care coordination, a contracted Coordinating Care Entity (CCE) which would oversee and manage the performance data, quality assurance and quality improvement activities and provide a Community Health Team (CHT) that would coordinate the social supports and services for the Medicaid-only and MME members. The CCE would coordinate the high touch care management with the existing CCC Nurse Care Managers integrated in the CCC Primary Care Practice sites, the EOHHS Office of Community Programs (OCP) Nurse Care Managers or the DEA Care Managers for the LTSS and CHT to provide linkages to social supports for a

coordinated, seamless delivery system. The Connect Care Choice Community Partners program will begin enrollment effective September 1, 2013.

#### **0375.10.10 Rhody Health Options- Overview**

Rhody Health Options 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 Options 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.

Members receiving Medicaid through the Rhody Health Options program 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 Executive Office of Health and Human Services (EOHHS) contracts with MCOs to provide these health services to members.

Effective September 1, 2013, Rhody Health Options will integrate the full range of Medicaid services (primary care, acute care, specialty care, behavioral health care and long-term services and supports) for all Medicaid eligible adults, including persons who are dually eligible for Medicaid and Medicare. Certain services for individuals with developmental disabilities and individuals with severe and persistent mental illness will not be included.

#### **0375.15 PROGRAM ELIGIBILITY for Rhody Health Options & Connect Care Choice Community Partners**

Rhody Health Options and the Connect Care Choice Community Partners Program are available for select populations who are:

1. Residents of Rhode Island;
2. Age twenty-one (21) and older;
3. Medicaid-only clients who receive Long Term Services and Supports
4. Medicare members who are eligible for full Medicaid benefits, and
5. Individuals not residing at Tavares, Eleanor Slater or an out of state residential hospital.

### **0375.20 Program Enrollment**

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

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

### **0375.25 Enrollment Process**

All Medical Assistance beneficiaries who meet the criteria within either Connect Care Choice *Community Partners* or Rhody Health Options Programs will receive written communications from EOHHS that will explain the options to the individual. A reasonable timeframe will be allowed for the individual to make a decision regarding these options. The individual will be enrolled into a participating Rhody Health Options MCO or the Connect Care Choice *Community Partners* program as the individual has indicated. If an individual does not respond within the timeframe the individual will be enrolled in either Rhody Health Options or Connect Care Choice *Community Partners* Program, with the option to change programs. The requested change will be effective on the first day of the following month of the requested change, in accordance with the EOHHS enrollment program schedule.

### **0375.30 Selection of a Managed Care Option**

The Connect Care Choice *Community Partners* and Rhody Health Options Programs are mandatory programs. Medical Assistance members are required to remain enrolled in one of these programs, but are authorized to transfer from one program to the other. The requested change will be effective on the first day of the following month of the requested change, in accordance with the EOHHS program enrollment schedule.

### **0375.35 Auto Re-Assignment After Resumption of Eligibility**

Medicaid members who are disenrolled from Connect Care Choice *Community Partners* or Rhody Health Options due to a loss of eligibility are automatically re-enrolled, or assigned, into the Connect Care Choice *Community Partners* 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 EOHHS Policy Section 0374.80.30, Enrollment Process.

#### **0375.40 Member Disenrollment by EOHHS**

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

1. Death
2. No longer eligible for Medicaid;
3. No longer eligible for LTSS (Medicaid-only clients)
4. Eligibility error;
5. Placement in Eleanor Slater Hospital, Tavares, or out of state residential hospital;
6. Incarceration
7. Adjudicative action
8. Moved out-of-state
9. Lack of participation in the program requirements

#### **0375.45 Requested Member Disenrollment**

The Connect Care Choice *Community Partners* Coordinating Care Entity (CCE) or Rhody Health Options MCO may request in writing that a member be disenrolled from the program because the member's continued enrollment in the Connect Care Choice *Community Partners* or Rhody Health Options MCO seriously impairs the CCE's or MCO's ability to furnish services to either the particular member or other members. The CCE or Rhody Health Options 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 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 their review. Members will be enrolled in one of the managed systems of care for their Medicaid funded services.

#### **0375.50 Formal Grievances and Appeals**

A. Connect Care Choice *Community Partners* members 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 Options members must exhaust the internal health plan appeals process before requesting a DHS Fair Hearing.

C. The contracted entities (CCE and 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. Expedited - A Health Plan must decide the appeal within seventy-two hours or three (3) 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.

3. 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. Appeals filed with the CCE fall into one (1) category: Non-Medical Care - If the grievance involves a problem other than medical care, the CCE must decide the grievance within thirty (30) days and all necessary information has been received by the CCE.

F. Rhody Health Options 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.

### **0375.55 Rhody Health Options Benefits**

The Rhody Health Options Program makes available the comprehensive benefit package to Rhody health Options members. The comprehensive benefit package includes Medicaid-funded medically necessary inpatient and outpatient hospital services, physician services, behavioral health services, (including

mental health and substance abuse services), family planning services, prescription drugs, laboratory, radiology and other diagnostic services, preventive care, and long-term care services and supports (LTSS).

The comprehensive benefit package does not include LTSS for individuals with SPMI and developmental disabilities provided through the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH). The health Plan agrees to coordinate with the BHDDH providers, but will not be responsible to deliver or to reimburse for services provided through BHDDH.

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 Medicaid-only clients. Medicare-funded prescription coverage will continue for Medicare covered prescriptions.

For Members of Rhody Health Options, prescription benefits shall be for generic drugs. Exception for limited brand coverage for certain therapeutic classes shall be granted if approved by the Executive Office of Health and Human Services (EOHHS), or the Managed Care Organizations acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below.

For purposes of approving exceptions to generic-first drug coverage for Medical Assistance recipients, EOHHS will determine certain Allowed Brand Name Therapeutic Classes / Single Agents drugs. EOHHS 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.

#### **0375.60 Connect Care Choice *Community Partners* Benefits**

The Connect Care Choice *Community Partners* Program will coordinate a comprehensive set of Medicaid State Plan benefits. In addition, the CCE will be responsible for the coordination of services with the case manager of other service delivery systems outside of the CCE and with the CCE's Community Health Team.

The comprehensive set of Medicaid State Plan benefits 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 Medicaid-only clients. Medicare-funded prescription coverage will continue for Medicare covered prescriptions.

For Members of Connect Care Choice *Community Partners*, Medicaid prescription benefits shall be pursuant to the 0300.20.05.35 Pharmacy Services, the Medicaid formulary and the generic drug policy outline in the Provider Manual.

It is the responsibility of the CCE to coordinate the Medicaid covered services with the Medicare covered services.

#### **0375.65 Mainstreaming / Selective Contracting**

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

The health plan also must accept responsibility for ensuring that network providers do not intentionally segregate Rhody Health Options 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~~ ~~COMM SUPPORTED LIVING ARRANGE~~

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

~~REV:07/2013~~

### ~~0374.05~~ ~~Legal Authority~~

~~REV:07/2013~~

~~During the 2005 General Assembly session, the Rhode Island legislature authorized the Rhode Island Executive Office of Health and Human Services (EOHHS) 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 members 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:07/2013~~

~~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 EOHHS quality and performance certification standards. Nurse care managers working with the physicians and members will ensure effective health care management and coordination of care for members who meet a moderate or high risk score as determined by the EOHHS. The program member 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 members at moderate or high risk as defined by the EOHHS also receive nurse care management services provided either through the physician practice, or directly contracted by EOHHS.~~

### ~~0374.15~~ ~~Rhody Health Partners- Overview~~

~~REV:07/2013~~

~~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.~~

~~Members 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 EOHHS contracts with MCOs to provide these health services to members.~~

### **0374.20 — Prog Elig for Rhody Patners + Connect Care**

REV:07/2013

~~Rhody Health Partners and the Connect Care Choice Program are available for select 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:07/2013

~~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:07/2013

~~All Medical Assistance members who meet the criteria within either Connect Care Choice or Rhody Health Partners Programs will receive written communications from EOHHS that will explain the options to the beneficiary. A reasonable timeframe will be allowed for the member to make a decision regarding these options. The member will be enrolled into a participating Rhody Health Partners MCO or the Connect Care Choice program as the member has indicated. If a member 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:07/2013~~

~~The Connect Care Choice and Rhody Health Partners Programs are mandatory programs. Medical Assistance members 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** ~~Auto Re-Assignment After Resumption of Elig.~~

~~REV:07/2013~~

~~Medicaid members who are disenrolled from Connect Care Choice or Rhody Health Partners 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 EOHHS Policy Section 0374.30, Enrollment Process.~~

### **0374.45** ~~Voluntary Disenrollment by the Member~~

~~REV:07/2013~~

~~Connect Care Choice and Rhody Health Partners members may choose to voluntarily disenroll from either the Connect Care Choice Program or the MCO option at any time. The disenrollment from either program will be effective no later than forty five (45) calendar days after the date on which the written request is received by EOHHS.~~

### **0374.50** ~~Member Disenrollment by EOHHS~~

~~REV:07/2013~~

~~Reasons for EOHHS 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;~~
- ~~— 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:07/2013~~

~~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 Health Partners 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 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 their review.~~

### **0374.60 Formal Grievances and Appeals**

~~REV:07/2013~~

~~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.~~

~~3. 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:07/2013

~~The Rhody Health Partners Program will provide a comprehensive set of In Plan Medicaid State Plan benefits, 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 EOHHS, or the Managed Care Organizations acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below.~~

~~—~~

~~For purposes of approving exceptions to generic first drug coverage for Medical Assistance recipients, EOHHS will determine certain Allowed Brand Name Therapeutic Classes / Single Agents drugs. EOHHS 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:07/2013

The mainstreaming of Medical Assistance members 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:07/2013

~~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 EOHHS reserves the right to make exceptions to CoC participation~~

~~when~~

~~clinically appropriate.~~

~~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~~

~~3. Member Outreach and Engagement~~

~~4. Assessment for Care Management and/or Peer Navigator~~

~~5. Development and Implementation of Personal Incentive/Reward Plan~~

~~—~~

~~0374.75.05 — Health Service Utilization Profile~~

~~REV:07/2013~~

~~The EOHHS 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 Ntwrk  
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 health care 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:07/2013~~

~~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 EOHHS 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:07/2013~~

~~EOHHS or its contracted MCO shall conduct outreach to eligible CoC member to identify reasons why the recipients opts to utilize the Emergency Department for a non 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, EOHHS 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:07/2013~~

~~Members identified for enrollment in CoC shall be assigned a care manager who will assist the client in developing an individualized care plan. CoC members may be 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 Dev. and Implementation of Pers. Rew/Inctv. 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.~~

## **0374.80 MANAGED CARE PROGRAM OPTIONS FOR INTEGRATED CARE FOR ADULTS WITH MEDICARE AND MEDICAID**

~~REV: 07/2013~~

### **0374.80.05 Legal Authority**

~~REV: 07/2013~~

~~By joint resolution pursuant to Rhode Island General Laws relating to the Medicaid Reform Act; Section 3 of Article 16: Integration of Care and Financing for Medicare and Medicaid Beneficiaries, the Executive Office of Health and Human Services (EOHHS), pursuant to RIGL 42-7.2-2(b), is directed to engage in a contractual arrangement for the expansion and integration of care management strategies by July of 2012 for Medicaid only beneficiaries and Medicare and Medicaid eligible (MME) members.~~

~~Title XIX and XXI of the Social Security Act and other applicable laws and waivers provides the legal authority for the States to administer their Medical Assistance Program. The Rhody Health Options 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 Community Partners option, 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 Community Partners or Rhody Health Options.~~

### **0374.80.10 Connect Care Choice Community Partners Program - Overview**

~~REV: 07/2013~~

~~Connect Care Choice Community Partners (CCCCP) is a Primary Care Case Management (PCCM) model managed care program for Medicaid eligible adults. Under the CCCCCP model, the strengths of Connect Care Choice (CCC) are combined with an enhanced capacity in care management and service integration across all service categories: primary care, acute care, specialty care, behavioral health and long term care services and supports. This preserves the core person-centered medical home aspect of the CCC and builds on the established chronic care model of best practices. For members needing LTSS, the LTSS care management and transition services would be performed by the state staff within the EOHHS Office of Community Programs (OCP) or Division of Elderly Affairs (DEA). To address the needs for greater integration of primary care, acute care, specialty care, behavioral health and long term care services and for high touch care coordination, a contracted Coordinating Care Entity (CCE) which would oversee and manage the performance data, quality assurance and quality improvement activities and provide a Community Health Team (CHT) that would coordinate the social supports and services for the Medicaid only and MME members. The CCE would coordinate the high touch care management with the existing CCC Nurse Care Managers integrated in the CCC Primary Care Practice sites, the EOHHS Office of Community Programs (OCP) Nurse Care Managers or the DEA Care Managers for the LTSS and CHT to provide linkages to social supports for a coordinated, seamless delivery system. The Connect Care Choice~~

~~Community Partners program will begin enrollment effective September 1, 2013.~~

### ~~0374.80.15 Rhody Health Options- Overview~~

~~REV: 07/2013~~

~~Rhody Health Options 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 Options 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.~~

~~Members receiving Medicaid through the Rhody Health Options program 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 Executive Office of Health and Human Services (EOHHS) contracts with MCOs to provide these health services to members.~~

~~Effective September 1, 2013, Rhody Health Options will integrate the full range of Medicaid services (primary care, acute care, specialty care, behavioral health care and long term services and supports) for all Medicaid eligible adults, including persons who are dually eligible for Medicaid and Medicare. Certain services for individuals with developmental disabilities and individuals with severe and persistent mental illness will not be included.~~

### ~~0374.80.20 Program Eligibility for Rhody Health Options & Connect Care Choice Community Partners~~

~~REV: 07/2013~~

~~Rhody Health Options and the Connect Care Choice Community Partners Program are available for select populations who are:~~

- ~~1. Residents of Rhode Island;~~
- ~~2. Age twenty one (21) and older;~~
- ~~3. Medicaid only clients who receive Long Term Services and Supports~~
- ~~4. Medicare members who are eligible for full Medicaid benefits, and~~
- ~~5. Individuals not residing at Tavares, Eleanor Slater or an out of state residential hospital.~~

### **0374.80.25 Program Enrollment**

REV: ~~07/2013~~

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

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

### **0374.80.30 Enrollment Process**

REV: ~~07/2013~~

~~All Medical Assistance beneficiaries who meet the criteria within either Connect Care Choice Community Partners or Rhody Health Options Programs will receive written communications from EOHHS that will explain the options to the individual. A reasonable timeframe will be allowed for the individual to make a decision regarding these options. The individual will be enrolled into a participating Rhody Health Options MCO or the Connect Care Choice Community Partners program as the individual has indicated. If an individual does not respond within the timeframe the individual will be enrolled in either Rhody Health Options or Connect Care Choice Community Partners Program, with the option to change programs. The requested change will be effective on the first day of the following month of the requested change, in accordance with the EOHHS enrollment program schedule.~~

### **0374.80.35 Selection of a Managed Care Option**

REV: ~~07/2013~~

~~The Connect Care Choice Community Partners and Rhody Health Options Programs are mandatory programs. Medical Assistance members are required to remain enrolled in one of these programs, but are authorized to transfer from one program to the other. The requested change will be effective on the first day of the following month of the requested change, in accordance with the EOHHS program enrollment schedule.~~

### **0374.80.40 Auto Re-Assignment After Resumption of Eligibility**

REV: ~~07/2013~~

~~Medicaid members who are disenrolled from Connect Care Choice Community Partners or Rhody Health Options due to a loss of eligibility are automatically re-enrolled, or assigned, into the Connect Care Choice Community Partners 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 EOHHS Policy Section 0374.80.30, Enrollment Process.~~

### **0374.80.45 Member Disenrollment by EOHHS**

REV: ~~07/2013~~

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

- ~~1. Death~~
- ~~2. No longer eligible for Medicaid;~~
- ~~3. No longer eligible for LTSS (Medicaid only clients)~~
- ~~4. Eligibility error;~~
- ~~5. Placement in Eleanor Slater Hospital, Tavares, or out of state residential hospital;~~
- ~~6. Incarceration~~
- ~~7. Adjudicative action~~
- ~~8. Moved out of state~~
- ~~9. Lack of participation in the program requirements~~

### **0374.80.50 Requested Member Disenrollment**

REV: ~~07/2013~~

~~The Connect Care Choice Community Partners Coordinating Care Entity (CCE) or Rhody Health Options MCO may request in writing that a member be disenrolled from the program because the member's continued enrollment in the Connect Care Choice Community Partners or Rhody Health Options MCO seriously impairs the CCE's or MCO's ability to furnish services to either the particular member or other members. The CCE or Rhody Health Options MCO may not request disenrollment of a member because of:~~

- ~~0 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 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 their review. Members will be enrolled in one of the managed systems of care for their Medicaid funded services.~~

### **0374.80.55 Formal Grievances and Appeals**

~~REV: 07/2013~~

~~A. Connect Care Choice Community Partners members 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 Options members must exhaust the internal health plan appeals process before requesting a DHS Fair Hearing.~~

~~C. The contracted entities (CCE and 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. Expedited — A Health Plan must decide the appeal within seventy two hours or three (3) 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.~~
  - ~~3. 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. Appeals filed with the CCE fall into one (1) category:~~

~~1. Non Medical Care — If the grievance involves a problem other than medical care, the CCE must decide the grievance within thirty (30) days and all necessary information has been received by the CCE.~~

~~F. Rhody Health Options 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.~~

## **0374.80.60 Rhody Health Options Benefits**

~~REV: 07/2013~~

~~The Rhody Health Options Program makes available the comprehensive benefit package to Rhody health Options members. The comprehensive benefit package includes Medicaid funded medically necessary inpatient and outpatient hospital services, physician services, behavioral health services, (including mental health and substance abuse services), family planning services, prescription drugs, laboratory, radiology and other diagnostic services, preventive care, and long-term care services and supports (LTSS).~~

~~The comprehensive benefit package does not include LTSS for individuals with SPMI and developmental disabilities provided through the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH). The health Plan agrees to coordinate with the BHDDH providers, but will not be responsible to deliver or to reimburse for services provided through BHDDH.~~

~~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 Medicaid only clients. Medicare funded prescription coverage will continue for Medicare covered prescriptions.~~

~~For Members of Rhody Health Options, prescription benefits shall be for generic drugs. Exception for limited brand coverage for certain therapeutic classes shall be granted if approved by the Executive Office of Health and Human Services (EOHHS), or the Managed Care Organizations acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below.~~

~~For purposes of approving exceptions to generic first drug coverage for Medical Assistance recipients, EOHHS will determine certain Allowed Brand Name Therapeutic Classes / Single Agents drugs. EOHHS 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.~~

### **~~0374.80.65 Connect Care Choice Community Partners Benefits~~**

~~REV: 07/2013~~

~~The Connect Care Choice Community Partners Program will coordinate a comprehensive set of Medicaid State Plan benefits. In addition, the CCE will be responsible for the coordination of services with the case manager of other service delivery systems outside of the CCE and with the CCE's Community Health Team.~~

~~The comprehensive set of Medicaid State Plan benefits 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 Medicaid only clients. Medicare funded prescription coverage will continue for Medicare covered prescriptions.~~

~~For Members of Connect Care Choice Community Partners, Medicaid prescription benefits shall be pursuant to the 0300.20.05.35 Pharmacy Services, the Medicaid formulary and the generic drug policy outline in the Provider Manual.~~

~~It is the responsibility of the CCE to coordinate the Medicaid covered services with the Medicare covered services.~~

### **0374.80.70 Mainstreaming / Selective Contracting**

~~REV: 07/2013~~

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

~~The health plan also must accept responsibility for ensuring that network providers do not intentionally segregate Rhody Health Options 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.~~