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Medicaid Code of Administrative Rules, Section 210-RICR-40-10-1, "Medicaid Managed Care Service Delivery Options"
Posted for Public Comment on August 6, 2018
Comment Period Ended on September 6, 2018
Date of Public Hearing: August 20, 2018
Summary Response to Comments September 07, 2018

	Respondent	Nature of the Comments	EOHHS' Response
1.	Amy Putrino Mediplan Advisers, Inc. August 20, 2018	Many of the thousands of people that Ms. Putrino works with are in a BlueCross, a United plan. They are on fee-for-service Medicare and Medicaid with just the stand-alone drug plan. "How this will affect them is one of my biggest questions to this group."	If eligible for enrollment into the Integrated Care Initiative, passive enrollment or voluntary enrollment would be offered. For those not eligible for passive enrollment, the beneficiary will be disenrolled from NHPRI and enrolled with Medicaid FFS. Services authorized by NHPRI will be honored by Medicaid FFS through June 30, 2019.
2.		I'm not sure if all of these people who are in another setting, in another plan right now are going to be passively enrolled into Integrity. If they are, this is not going to serve them well. Many of them were passively enrolled in Integrity and came out. Integrity has the smallest network of doctors in the state and the smallest formulary for medications.	NHPRI is the only managed care organization (MCO) enrolling beneficiaries into the managed care program. PACE also provides the fully integrated services for Medicare and Medicaid members that choose to enroll with PACE.
3.		So, moving forward, all of the services that were coordinated by Unity, how will they be taken care of?	The services will be managed by state staff and a contracted entity.
4.		Anything that was taken care of by a case manager, so the Ride Program, mental health services, Medicare coordination, where do these people stand if they don't go into Integrity? Do they lose these services now that are now provided by the State? It is a big impact.	The services will be managed by state staff, the contracted entity or the AHS.
5.		Even the people who have received letters stating that they have to do something for this not to happen don't understand what they are going through, and my job is to guide them through that, so I need to know how that's going to happen.	EOHHS is providing training session with stakeholders. EOHHS and NHPRI are providing updates on the respective websites.
6.	Ray Gagney Rhode Island Organizing Project August 20, 2018	We are particularly concerned about the Medicaid-only population. These are very vulnerable people. We are worried about the continuity of care of their long-term services and supports. We are particularly concerned about their access to specialists. We ask that this population, which is probably less than a thousand, be kept in managed care.	EOHHS will enroll Medicaid-only in the community with community-based LTSS in Rhody Health Partners and carve out the community-based LTSS services. The carved-out community-based LTSS services will be paid for by Medicaid FFS.
7.		We don't have an ASO chosen to manage this program, and we are afraid that whole care coordination piece is going to go down the tubes in the short run, and then there is going to be massive confusion.	EOHHS is committed to providing continuity of care until a permanent solution for all of the Medicaid FFS population.
8.		I was at the Warwick Senior Center last week and the director said people are starting to get their letters and there's mass confusion here. We got a call on Thursday or Friday to our partner's office at the Senior Agenda Coalition. This person is a Unity member. She accesses mental health services. She got her letter.	EOHHS and NHPRI have addressed call center staff re-training as priority issue. NHPRI is educating staff.

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		She found out that Integrity is not going to work for her. Her doctor is not part of the Integrity network. She called the line provided on the letter she received from EOHHS, and she feels like she didn't get the answer.	
9.	Samuel Salganik, Esq. Health Policy Analyst RIPIN September 6, 2018	*Continuity of Care* – Beneficiaries transitioning from Rhody Health Options (RHO) into FFS Medicaid should be guaranteed continuity-of-care under a clearly articulated set of circumstances. RIPIN suggests that Section 1.6(B) be replaced with the following language: "Medicaid beneficiaries who were enrolled in RHO as of September 30, 2018, who were receiving services on or around that date that are funded by Medicaid as the primary payer, and who transition to Medicaid fee-for-service will be entitled to continuity of care protections. These continuity protections will ensure their continued access to these Medicaid-funded services through June 30, 2019. Through that date, EOHHS and/or DHS will waive and/or consider satisfied any and all prior authorization, medical review, or other processes with respect to these services, at least at the level at which they were being provided by NHPRI immediately prior to the termination of RHO. The only potential exception would occur if the services were being delivered through a provider who does not participate in Medicaid fee-for-service. In this circumstance, EOHHS will provide all possible cooperation to add this provider to their network or sign a single-case agreement. If that is not possible, then EOHHS will make available the same service at the same level through a provider within its network. At no time during the continuity period will EOHHS or DHS refuse to pay for any such service provided by a fee-for-service participating provider, nor shall EOHHS or DHS require the provider or patient to complete any additional authorization or other administrative process before timely payment to the provider can be made."	The EOHHS appreciates the commenter's concerns about the transition of RHO members and is developing a detailed plan to ensure the process will not disrupt the continuity of care or impede access to or the quality of services. In our on-going effort to be as transparent and open as possible on the RHO initiative, we welcome the participation of the community in the development of this plan and will continue to seek input in every phase of the transition. The rights of beneficiaries with respect to access, coverage, and continuity of care are covered in great detail in other sections of this rule as well as in §10-05-2. In general, the EOHHS does not consider a rule to be the appropriate forum for addressing the type of procedural issues raised by the commenter related to the transition from RHO. In addition, specific concerns related to access and payment are more effectively dealt with in provider contracts and agreements.
10.		*Delay Elimination of RHO* - The elimination of (RHO) should be delayed beyond the end of September, to allow sufficient time for planning, setting up the next care management model, and communication with members so that they can make informed choices about their model of care. From a regulatory language perspective, this could be achieved by changing the dates in Section 1.6(A) to reflect a delay in the elimination of RHO.	The EOHHS is not delaying the implementation of the RHO initiative at this writing. Every effort is being made to ensure care continuity and provide applicants and beneficiaries with the timely information they need to make reasoned choices about their service delivery options.
11.		*Managed Care for Medicaid-Only (RO80s)* – RHO enrollees with only Medicaid (so-called "RO80s") should have access to a managed care plan. We believe that at least the following regulatory changes are required: Section 1.3.3 – Suggest adding a new provision clarifying that Medicaid	The rule has been revised to clarify that Medicaid-only RHO members receiving Medicaid LTSS in the home and community-based setting will be transitioned to an RHP plan for primary care services. All Medicaid LTSS for these beneficiaries

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		beneficiaries from any eligibility category who receive LTSS longer than thirty (30) days will be transitioned into the RHP line of MCO coverage, though the base financial Medicaid eligibility criteria will not change. (For example, a RIte Care enrollee who needs LTSS for longer than 30 days will transition into RHP, but they will not become subject to the income or resource standards of EAD Medicaid.) Section 1.3.5(A)(1) – Eliminate item (e) ("Placement in a long-term care institution – such as a nursing facility – for more than thirty (30) consecutive days") and item (h) ("Eligibility for Medicaid LTSS in the community or in a facility") from the list of reasons for which a member can be disenrolled from RHP. Section 1.4(A)(4) – The RHP benefit package will need to be updated to include the new carve-out of LTSS services after the first 30 days. Section 1.6(A) should state that RO80s will be transitioned to RHP. Recommend adding "dual-eligible" between "June 22, 2018" and "Medicaid beneficiaries." Also recommend adding two sentences at the end of the provision to read: "RHO enrollees who do not have Medicare coverage (so-called "Medicaid-onlys" or "RO80s") will be transitioned into Rhody Health Partners as of October 1, 2018. LTSS services for these beneficiaries will be an out-of-plan benefit, financed through fee-for-service Medicaid." Section 1.6(C) – RO80s who are transitioned into fee-for-service (FFS) should have appeal rights, because that would be a mistake. Suggest adding the clause "as a direct result of and in accordance with the terms of this regulation" between "have been placed in fee-for-service arrangements" and "will not have access." Additionally, with respect to Section 1.6(C) - This class of Medicaid beneficiaries does not lose access to all appeal rights. Rather, they cannot appeal the specific loss of RHO that is happening by virtue of the regulatory change. Recommend replacing "will not have access to appeal rights" with "will not have access to appeal the loss of their RHO MCO coverage." Suggest adding a new Section 1.6(D) to clarify: "Medicaid-Only RHO enrollees: Those RHO enrollees who do not have Medicare (so-called "RO80s" or "Medicaid-onlys") shall be transitioned into Rhody Health Partners, with LTSS services provided as a carved-out out-of-plan benefit. This transition shall be seamless with no gap in MCO coverage. Continuity protections described in section 1.6(B) shall also apply for this population." Other regulations – Some other Medicaid regulations may also need to be revised to incorporate this policy change. For example, 210-RICR-30-05-2 (on MCO service delivery options for ACA coverage groups), contains a section (2.50(A)(8))	will be provided on a fee for service basis. Medicaid-only applicants and beneficiaries receiving care in a health institution such as a nursing facility do not have a managed care option post-RHO beyond the initial 30 days. The EOHHS has clarified the rule to reflect the RHP benefits related to the RHO termination for both for Medicaid only and dually eligible beneficiaries in these and all other applicable provisions in this Part. The EOHHS has modified the provision on appeal rights to address the commenter's concerns. Amendments to other Parts of the Medicaid administrative rules are in draft form. The EOHHS will correct the discrepancy noted when these amendments move forward.

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		that lists long-term placement in a nursing home as an allowable reason for MCO disenrollment. There may be other provisions as well in other regulations that need to be cleaned up.	
12.		*Seamless MMP Enrollment for "New Duals"* – Medicaid beneficiaries gaining Medicare eligibility ("new duals") should be passively enrolled into the Medicare-Medicaid Plan (MMP) to allow for a seamless transition. We recommend adding a new Section 1.7.5(B)(3) that would read: "New Duals – For Medicaid recipients becoming newly eligible for Medicare, EOHHS is authorized, at its option when business and IT processes are in place, to initiate a process for seamless auto-enrollment from Medicaid managed care into the MMP, with the beneficiary receiving notice and the opportunity to opt-out. As a critical element of this process, EOHHS (and/or DHS) will need first to determine whether the beneficiary will continue to be eligible for Medicaid after their Medicare becomes active (which will typically require an eligibility determination under a new Medicaid eligibility category). This redetermination must take place before their Medicaid (and managed care plan) is terminated. For those who will remain Medicaid-eligible, the State will then need to provide sufficient advance notice clearly articulating the changes, explaining the passive enrollment into the MMP, and allowing the beneficiary the opportunity to opt-out, in line with the notice principles enumerated elsewhere in this regulation."	The EOHHS is not planning to qualify this section of the rule as recommended by the commenter at this time as it is prospective. Note that all Medicaid beneficiaries are evaluated for other eligibility categories prior to termination of coverage on a routine basis. Eligibility for or enrollment in Medicare is not a bar to Medicaid eligibility, but effects coverage group and, therefore, service delivery options. We will take the commenter's proposed changes into consideration while re-evaluating current policy and procedures in this area in the months ahead.
13.	Linda Katz Voices for Better Health, RI Organizing Project, The Senior Agenda, The Economic Progress Institute September 6, 2018	As we have communicated to EOHHS leadership, we believe that the transition from Unity (and Rhody Health Options – RHO) is happening much too quickly, without adequate time to develop the care management entity that will provide the important services currently provided directly by NHPRI or through contract with community providers; or to provide members with adequate information to decide what service delivery system they wished to enroll in. We hoped that the transition could be extended for an additional 3 months, at least. We understand this 'ask' is beyond the scope of the regulations – but hope that the following changes to the rules can be made to best protect both current Unity members and those who 'would have become' Unity members – i.e., Medicare beneficiaries who become eligible for Medicaid and Medicaid-only beneficiaries who become eligible for long term services and supports (LTSS).	The EOHHS is not delaying the implementation of the RHO initiative at this writing. Every effort is being made to provide applicants and beneficiaries with care transitions that assure access and quality. We are also committed to providing applicants, beneficiaries and their families with the timely information they need to make reasoned choices about service delivery.
14.		The budget Article authorizing the transition from Unity, only authorized EOHHS to transition the dually-eligible, not the MA-only population. State law allows and encourages all Medicaid beneficiaries to be enrolled in managed care. For both the 'transitioning' MA-only Unity members and MA-only who are newly eligible for LTSS, the rules need to reflect continued enrollment in RHP and provision of LTSS through Fee-for-Service (e.g., the chart at 1.1B needs to show continued RHP for an MA individual who needs LTSS more than 30 days); Section 1.3 needs to reflect	The rule has been amended to clarify the commenter's concerns about service delivery for Medicaid-only RHO members.

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		MCO + FFS (LTSS) for MA-only individuals as a 'service delivery option.' It is no longer accurate that "Beneficiaries participating in RHO on /before October 1, 2018 will obtain all their Medicaid covered services on a FFS basis after this date" – the MA-only members in RHO will still have managed care for primary care.	
15.		EOHHS plans to contract with a new entity to provide care management services. EOHHS should allow beneficiaries who are currently receiving care management through a community-based agency to continue to receive services from that provider until the new entity is established and ready to take on members. EOHHS can pay those providers on a FFS basis. We note that the new entity will not only need to serve those transitioning out of Unity but newly eligible individuals who require this service.	The commenter's concerns are being taken into account in the transition plan and proposals under development for improving service delivery for this population going forward.
16.		The rules for Service Delivery Option (1.3) should be amended to provide for continued care management with their current provider for Unity beneficiaries who receive services from a community-based provider. Unless the MCO will provide care management for the MA-only members who need LTSS – and this will be instead provided through FFS – the rule should be amended (at 1.3(A)(4) to omit the limitation that the care management entity does not provide services to individuals enrolled in managed care.	The commenter's recommendations are being addressed in the transition plan under development. EOHHS will make any changes in the provision noted deemed necessary once this process in complete. Note: federal regulations related to conflict free case management that apply with respect to HCBS in this area are now under review.
17.		EOHHS has informed Unity beneficiaries that the 'most Medicaid funded services authorized by NHPRI will be covered in Medicaid FFS through June 30, 2019'. The rules at "Rhody Health Option" 1.6 should explain this right, what happens if the current provider does not accept FFS, etc. We concur with the regulatory language proposed by Sam Salganik in his comments.	Continuity of care provisions noted are specific to providers. The EOHHS is working with providers to amend agreements and contracts are
18.		We recommend that subsection C regarding appeals, be amended to clarify that an individual who disagrees with the scope of coverage or service is eligible to file an appeal. While transition from Unity to FFS as a whole may not be appealable, if there is impact on an individual's access to service, that is appealable.	The commenter's proposed amendments to the rule have been made.
19.			