June 30, 2009

TO: Interested Parties

FROM: Anthony Marple, Director, Office of MaineCare Services

SUBJECT: Proposed Rule: MaineCare Benefits Manual, Chapter IV, Restriction Plans

This letter gives notice of a proposed rule: MaineCare Benefits Manual, Chapter IV, Restriction Plans

The proposed rule restructures the restriction plans from two to four plans to improve the health care of MaineCare members and to integrate Member Lock-In plans with the new MaineCare claims system, Maine Integrated Health Management System (MIHMS). Lock-In type 1 requires a member to be restricted to a designated Primary Care Physician, a Hospital, a Prescriber, a Pharmacy and any other applicable health care professional. Lock-In type 2 restricts the member to one or multiple types of health care providers. Lock-In type 3 restricts the member to one or multiple specific prescriber(s) for their prescriptions. Lock-In type 4 restricts the member from being able to obtain a specific drug category (class). Additionally, the rule is renamed.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at or, http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html or a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

A concise summary of the proposed rule is provided in the Notice of Agency Rule-making Proposal. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Proposal.
Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, Office of MaineCare Services

RULE TITLE OR SUBJECT: MaineCare Benefits Manual, Chapter IV, Restriction Plans

PROPOSED RULE NUMBER:

CONCISE SUMMARY: The proposed rule restructures the restriction plans from two to four plans to improve the health care of MaineCare members and to integrate Member Lock-In plans with the new MaineCare claims system, Maine Integrated Health Management System (MIHMS). Lock-In type 1 requires a member to be restricted to a designated Primary Care Physician, a Hospital, a Prescriber, a Pharmacy and any other applicable health care professional. Lock-In type 2 restricts the member to one or multiple types of health care providers. Lock-In type 3 restricts the member to one or multiple specific prescriber(s) for their prescriptions. Lock-In type 4 restricts the member from being able to obtain a specific drug category (class). Additionally, the rule is renamed.


THIS RULE WILL X WILL NOT HAVE A FISCAL IMPACT ON MUNICIPALITIES.

STATUTORY AUTHORITY: 22 M.R.S.A., § 42, § 3173

PUBLIC HEARING:

Date: July 31, 2009 9-11AM
Location: Conference Room # 1A & B
Department of Health and Human Services
Office of MaineCare Services
442 Civic Center Drive
Augusta, ME

Any interested party requiring special arrangements to attend the hearing must contact the agency person listed below before July 24, 2009.

DEADLINE FOR COMMENTS: Comments must be received by midnight, Monday, August 10, 2009.

AGENCY CONTACT PERSON: Ginger Roberts-Scott, Comprehensive Health Planner
AGENCY NAME: Office of MaineCare Services
ADDRESS: 442 Civic Center Drive
11 State House Station
Augusta, Maine 04333-0011

TELEPHONE: 207-287-9365 FAX: (207) 287-9369 TTY: 1-800-423-4331 or 207-287-1828 (Deaf or Hard of Hearing)
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1.01 INTRODUCTION

The Restriction Plan is an administrative procedure where certain MaineCare members who have a history of over-utilizing MaineCare benefits must receive their primary medical care from one health care provider, and when indicated, one hospital, one pharmacy and specified additional providers, (such as a behavioral health provider, dentist, eye care provider). The Department of Health and Human Services anticipates that restricting members who over-utilize services to a single primary care provider will result in better health care management and the reduction of the total cost of care.

1.02 STATEMENT OF PURPOSE

1.02-1 The purposes of the Restriction Plan are:

A. To decrease and control over-utilization and/or abuse of MaineCare covered health care services and/or benefits, and to minimize medically unnecessary and addictive drug usage;

B. To establish a method of monitoring non-emergency health care services for MaineCare members who have utilized MaineCare health care services or benefits at a frequency or in an amount that is not medically necessary; and

C. To assist members through education and referral towards appropriate health care service and benefit use.
1.03 DEFINITIONS

For purposes of this Section, the following definitions shall apply:

1.03-1 **Authorized Agent** is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

1.03-2 **Health Care Provider** is an individual or entity that furnishes health care services or benefits to persons for which payment is reimbursable through the MaineCare Program.

1.03-3 **Health Care Services** are all services covered under the Maine Medical Assistance Program. These services include, but are not limited to, primary care provider, pharmacy and hospital services.

1.03-4 **Lock-In** is a federally authorized program specified in the Code of Federal Regulations (42 CFR § 431.54 (e)) that provides that a MaineCare member who has utilized MaineCare services at a frequency or amount that is not medically necessary may be restricted to designated health care providers that are enrolled as MaineCare providers, with consideration for the members needs. Maine Integrated Health Management System (MIMHS) will be the system of record for the Lock-In. Lock-In will only be deemed necessary once the Member Review Team has determined that the member has exhausted all educational opportunities. The Team may enroll a member in a Lock-In corresponding to the type and/or in consideration of the degree of Over-Utilization by the member. Lock-In restrictions do not apply to emergency services, that is stabilization of an emergency medical condition as defined in Section 1.02-4 of Chapter I of the MaineCare Benefits Manual. There are four types of Lock-in:

A. **Full Restriction (Lock-In type 1)** - This Lock-In type requires a member to be restricted to a designated Primary Care Physician, a Hospital, a Prescriber, a Pharmacy and any other applicable health care professional. Full restriction will occur when Over-Utilization has been pervasive across provider type and long lasting at high cost. When a member is under Full Restriction, all claims for services that were not delivered by a designated provider (s) or were not referred by a designated provider will suspend for review and may be denied.

B. **Partial Lock-In (Lock-In type 2)** – This Lock-In type restricts the member into one or multiple types of health care providers. The Member Review Team will choose which provider type(s) the member will be subject to Lock-In and only those claims with those provider types will be monitored.
1.03  DEFINITIONS (cont)

C. **Prescriber Lock-In (Lock-In type 3)** – This Lock-In type will restrict the member to the specific prescriber(s) for prescriptions. The Member Review Team may designate multiple prescribers for the member for differing types of prescriptions. Claims will be denied if the prescription is not written by the designated prescriber(s).

D. **Pharmaceutical Restriction (Lock-In type 4)** – This Lock-In type restricts the member from being able to obtain a specific drug category (class). The Member Review Team may choose to have multiple prescribers for the member for differing types of prescriptions. Claims will be denied if the prescription is not written by the designated prescriber(s). Additionally, early refills will not be allowed under any circumstances.

1.03-5  **Maine Integrated Health Management Solution (MIMHS)** – is the computer system that MaineCare Services of The Department of Health and Human Services (DHHS) uses to process provider claims for reimbursement as of March 2010.

1.03-6  **Medical Necessity** is the use of health care services or benefits that are appropriate to, and not in excess of, the health care needs of the member, as determined by the Member Review Team through investigation and analysis of the medical record and claims history. Potential indicators of the lack of medical necessity include but are not limited to:

A. unusually frequent utilization of health care services;

B. inappropriate or excessive acquisition of drugs, especially drugs with addictive properties such as: tranquilizers, psychostimulants, narcotic analgesics, non-narcotic analgesics, sedative barbiturates and sedative non-barbiturates; and

C. duplicated services or prescriptions for the same or similar conditions.

1.03-7  **Members** are recipients of MaineCare services.

1.03-8  **Member Review Team (“the Team”)** is the Department of Health and Human Services (DHHS) multidisciplinary team that participates in the surveillance of health care services and benefit utilization by MaineCare members and determines the existence of over-utilization and/or misuse. The Team shall consist of, at a minimum, a physician; a registered nurse or social worker; and a representative of Program Integrity. The Team may also include other consultants, such as a pharmacist and/or a representative from the Health Care Management unit of MaineCare services.

1.03-9  **Over-Utilization** is the use of health care services and benefits in excess of medical necessity, as determined by the Member Review Team.
1.03 DEFINITIONS (cont)

1.03-10 Primary Care Provider (PCP) is a physician or other provider who practices primary care.

1.03-11 Program Integrity Unit is the unit responsible for conducting a federally required monitoring plan that reviews all MaineCare services and expenditures.

1.03-12 Prescriber is an M.D., D.O., nurse practitioner, physician assistant or resident in training who possess a valid DEA number.
1.03  DEFINITIONS (cont)

1.04  MANDATORY ENROLLMENT OF MEMBERS IN THE RESTRICTION PLAN

1.04-1  Identification of Members

A.  The Program Integrity Unit will identify members who appear to be obtaining health care services that are not medically necessary. Members who are suspected of obtaining health care services that are not medically necessary may be identified by the following sources:

1.  Referrals or complaints from members, providers, professional associations, health care professionals and other citizens;

2.  Referrals from the Department of Health and Human Services (“DHHS”), Office of MaineCare Services, Fraud Investigation and Recovery Unit, the Department of Attorney General, Health Care Crimes Unit, third party payers, State of Maine Board of Pharmacy, the Health and Human Services Office of Inspector General (OIG), Center for Medicare and Medicaid Services (CMS), State and local law enforcement agencies, and any other State or Federal agency;

3.  Computer generated reports that identify members who may be over-utilizing or inappropriately using health care services.

B.  Following the identification of members who appear to utilize health care services that are not medically necessary, the Program Integrity Unit may:

1.  Analyze the computer-generated profiles of the member’s reimbursed health care services for the previous six (6) months, or longer if indicated;

2.  Review the member’s clinical records to document the medical necessity as well as the frequency of services billed, and if necessary;

3.  Communicate with the key providers to determine if over-utilization is occurring.
MANDATORY ENROLLMENT OF MEMBERS IN THE RESTRICTION PLAN

C. Upon completion of the initial review process, DHHS or its Authorized Agent may contact the member who appears to have over-utilized health care services, to discuss the member’s pattern of utilization of health care services. During the contact, the DHHS or its Authorized Agent shall review a summary of the member’s primary care provider, pharmacy and hospitalization or other service usage and the member shall be given an opportunity to explain his or her utilization pattern. In addition to explaining the Restriction Plans, DHHS or its Authorized Agent may also provide information on how to obtain appropriate health care services or refer the member to an appropriate agency to obtain services for an identified problem.

D. DHHS or its Authorized Agent shall make notes to document the content of the contact, member responses and any referrals. DHHS or its Authorized Agent shall provide the member with a contact name and office telephone number as resources.

E. DHHS or its Authorized Agent shall refer the case to the Member Review Team for evaluation in cases where no apparent medical necessity for the health care services exists and/or over-utilization continues.

1.04-2 Member Review Team - Case Evaluation
The Member Review Team shall review cases referred under the preceding Section to evaluate the utilization and medical necessity of the health care services rendered to members. The Member Review Team shall summarize its findings and recommendations in writing. The Team may recommend:

A. That the member be monitored by DHHS or its Authorized Agent until more documentation and information is available.

B. That DHHS or its Authorized Agent contact the member to discuss, verbally or through written communication, the member’s health care utilization and concerns. The DHHS or its Authorized Agent will inform the member of the benefits of proper health care utilization and assist the member, if necessary, in securing a health care provider.
1.04  MANDATORY ENROLLMENT OF MEMBERS IN THE RESTRICTION PLAN

Unit representative will also explain the Restriction Plans that could be implemented should the current pattern of utilization continue.

C. That the member be enrolled in one of the four types of Lock-In of the Restriction Plan for restriction to a health care provider, pharmacy, hospital and/or other provider as necessary in order to improve the member’s health care benefits usage. The Team may recommend an initial enrollment in the Restriction Plan for a period not to exceed twenty-four (24) months. Subsequent re-enrollment periods, if necessary, are limited to twelve (12) month periods.

1.04-3  Member Review Team –Plan Criteria

A. Restriction Plan Criteria

The Team may elect to enroll the member into the Restriction Plan if the member has exceeded medically necessary utilization of medical services or benefits. The Team determines over-utilization on a case-by-case basis that includes an evaluation of the member’s medical condition and need for services as determined using relevant information including but not limited to the medical record, claims data and national standards for best practices. The member must retain reasonable access to MaineCare services of adequate quality, including consideration for geographic location and reasonable travel time.
1.04-4 Member Notification

A. If the Member Review Team’s decision is to enroll the member in the Restriction Plan, the Program Integrity Unit shall mail a Notice of Decision to the member and provide the member with:

1. The Team’s decision,
2. A summary of the evidence upon which the Team’s decision was based,
3. The effective date of the restriction and/or enrollment into the Plan,
4. Citation of the rules supporting the Team’s decision,
5. A health care provider and/or prescriber designation form, and
6. Notice of the member’s right to request an administrative hearing and appeal the Team’s determination in accordance with the Maine Medical Assistance Manual, Chapter I, and Chapter IV.

B. The member shall have thirty (30) days from the receipt of the Notice of Decision to complete the health care provider and/or prescriber designation form and return it to the Team. If the member fails to return the completed health care provider and/or prescriber designation form or otherwise notify the Program Integrity Unit of his/her designation of health care providers and/or prescriber, staff of the Program Integrity Unit shall select the member’s health care providers and/or prescriber based on the member’s medical needs and geographic location.

C. Selection of the health care provider(s) and/or prescriber by the Program Integrity Unit staff or through oral notice by the member shall be so documented in the
1.04 MANDATORY ENROLLMENT OF MEMBERS IN THE RESTRICTION PLAN

Member’s file. Enrollment in the Restriction Plan shall not begin until after the member has had an opportunity for an administrative hearing, if requested. If a hearing is not requested by the member within thirty (30) days of the date of the Notice of Determination, then the member’s enrollment in the Restriction Plan shall become effective immediately upon confirmation with the participating health care providers.

1.04-5 Provider Notification

The Program Integrity Unit will contact by telephone each health care provider and/or prescriber selected, to explain the Restriction Plan and solicit the provider’s participation and cooperation. If the provider agrees to participate as the health care provider and/or prescriber for the member, a follow-up letter shall be sent by the Program Integrity Unit to the provider confirming his/her participation and the date on which the restriction shall begin.

1.05 EMERGENCY HEALTH CARE SERVICES AND NON-PRIMARY CARE PROVIDERS

Non-primary care providers shall be reimbursed for health care services only in the following circumstances:

A. In an emergency situation where written or verbal verification of the emergency treatment is provided, when requested by the Program Integrity Unit;

B. When the member has been referred by the primary care provider; and

C. When the member has received services without a referral from providers whose category of service is not covered by the restriction plan, i.e., x-ray, laboratory, and optometrists.

1.06 PLAN MONITORING

During the period of enrollment in the Restriction Plan, the Program Integrity Unit will supervise and monitor utilization patterns of restricted members and analyze computer-generated profiles of the member’s health care services reimbursed under
1.04 MANDATORY ENROLLMENT OF MEMBERS IN THE RESTRICTION PLAN

MaineCare. The member will be contacted by the Program Integrity Unit periodically to verify that his or her medical needs are being met.

The member shall receive the Program Integrity Unit’s toll-free telephone number, to clarify questions regarding restriction, seek assistance if access problems arise, and report complaints.

1.07 CHANGE IN HEALTH CARE PROVIDER

At the time the member is notified of his/her enrollment in the Restriction Plan, the member shall be advised that he/she may change his/her health care provider for any reasonable cause at a later date, by notifying the Program Integrity Unit. Program Integrity Unit Staff shall contact the proposed health care provider and arrange his/her participation in this member’s restriction plan. If the member, or health care provider, believes a second opinion is warranted or desirable, the second opinion provider payment may be authorized by contacting the Program Integrity Unit staff in advance of the second opinion.

1.8 CHANGE IN MEMBER STATUS IN RESTRICTION PLAN

1.8-1 Continuation of restriction, or modification of enrollment into another Lock-In type, beyond the initial period will be recommended when subsequent annual reviews of the member’s records, claims data and national standards, in accordance with the MaineCare Benefits Manual, Chapter IV, by the Member Review Team indicate one or more of the following:

A. Evidence of member’s failure to comply with the recommended plan of management from the health care providers;

B. Evidence of member’s continued over-utilization of services without medical necessity, which includes services where payments were denied by MaineCare because the Restriction Plan protocols were not followed; or

C. Member’s voluntary request to continue the restriction.
1.8 CHANGE IN MEMBER STATUS IN RESTRICTION PLAN

1.8-2 In cases where the Member Review Team determines that the enrollment in the Restriction Plan should continue beyond the initial period, the member shall be notified in writing by a Notice of Decision.

The Notice of Decision shall include the evidence used in the determination and member’s right to request an administrative hearing in accordance with the MaineCare Benefits Manual, Chapter I, and Chapter IV.

1.8-3 When the Member Review Team determines that the member’s utilization practices have significantly improved, the health care provider restriction shall be terminated on a date designated by the Member Review Team. The member shall be notified by mail of the termination of restriction and the effective date of termination. The Program Integrity Unit shall notify the member that his/her MaineCare utilization shall be monitored to insure that the improved utilization pattern is maintained. Should previously observed over-utilization practices become evident during the monitoring period, the member’s case shall be reviewed in accordance with Chapter IV, Section I.

1.9 MEMBER RIGHTS

A. A member who disagrees with the determination that he/she be enrolled in the Restriction Plan, or a member who is aggrieved by an action or policy relating to his/her involvement or continued reenrollment in the Restriction Plan is entitled to oppose the action. He/she shall be informed of his/her rights to appeal. Appeals Rights are in accordance with MaineCare Benefits Manual, Chapter I.