Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

AETNA BETTER HEALTH® OF KENTUCKY

What does it mean if I am enrolled in the Lock-In program?

What do I need to do?

There are different types of Lock-In. Please read your letter carefully, so you know which one applies to you. Please look at your letter for the date you will be enrolled in the Lock-In program. This date is when the changes will take place.

Primary Care Physician (PCP) and Pharmacy Lock-In Program

If you have been enrolled in the PCP and Pharmacy Lock-in program, you need to schedule an appointment with the PCP named on your letter. The PCP named on your letter is the only provider who can write prescriptions for you at this time.

You'll need a referral to see other doctors

If you have other doctors or specialists you see or are planning to see, your PCP must fax us a referral before you go. If we don't have the requested referral approved and on file, we can't cover your visit. Also, without this approval, we won't be able to cover any prescriptions or other tests the other provider may order. A copy of the referral form is attached for you.

Here's what you need to do before you fill a prescription:

- Make sure you get your prescription from only --
  - Your PCP *or*
  - A provider with an approved referral
- Take your prescription to the pharmacy named in your letter. Make sure:
  - This pharmacy can meet your needs
  - The pharmacy's business hours work for you
  - You can get delivery if you need it
- Check our preferred drug list to see if you need pre-approval of this drug. If you do, you'll need to have a "prior authorization" request from your doctor.

This doesn't apply to all medications. Ask your doctor about it at your appointment.

Hospital Lock-In Program
If you have been enrolled in the Hospital Lock-in Program, it means you can go to your assigned hospital for non-emergency care.

Remember --

- You should see your PCP for routine care (colds, flu, back pain, infections, blood pressure checks, diabetes checks, etc.)
- You should always try to contact your PCP first as they know your health care needs best.
- The 24-Hour Nurse Line is available to call for any after-hours questions. The nurse can help you decide if you can wait to see your PCP the next day or if you should go to an urgent care center. The number is **1-800-556-1555**.

If you have an emergency, you should go to the nearest Emergency Department or call 911. However, if you go to the emergency room for non-emergency care, you may have to pay a co-pay.

You may go to an in-network facility for tests, lab work or inpatient procedures if referred by your doctor. Some tests, lab work and inpatient procedures will require prior authorization from your doctor. It is your responsibility to make sure any procedure that is not an emergency does not need prior authorization. If it does, you should make sure that it has been sent in and approved. You can either check with your PCP or call Member Services with any questions.

If you want to ask for a change to your PCP or pharmacy, please call Member Services at **1-855-300-5528**. Lines are open 7 a.m. to 7 p.m., Monday through Friday, Eastern Time (TTY users dial **711**, TDD users dial **1-800-627-4702**).

Please make certain your address and phone number on file with the Department for Community-Based Services is current. If you need to make a change, please call **1-855-446-1245** or your local Department for Community-Based Services office.

To receive a translated copy of this document, call Member Services at **1-855-300-5528**.

Para recibir una copia traducida de este documento, llame al servicio para miembros al **1-855-300-5528**.

AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Member Restriction Program	Page:	1 of 6
Department:	Medical Management	Policy Number:	7500.03
Subsection:	Care Management	Effective Date:	02/01/2016
Applies to:	■ Kentucky Medicaid Managed Care		

PURPOSE

Aetna Better Health has adopted Member Restriction Program AMA 7500.03. There are requirements for Aetna Better Health that deviate from those detailed in the Member Restriction Program AMA 7500.03 Policy.

This amendment will be used in conjunction with the 7500.03 corporate policy to comply with the Aetna Better Health Medicaid regulatory and legislative requirements.

Within this policy Amendment, the Member Restriction Program will be referred to as the Lock-In Program

PURPOSE will be modified so that in addition to the existing provisions:

- Aetna Better Health uses the Lock-In Program to assist identified enrollees in better utilizing their available benefits to obtain the best overall health outcome:[1].

DEFINITIONS will be modified so that in addition to the existing provisions:

Aetna Medicaid Administrators LLC (AMA)	A subsidiary of CVS Health Corporation, AMA is the company's national Medicaid subsidiary that provides plan management and other administrative services for the Medicaid programs nationally.
Enrollee	A person insured or otherwise provided coverage by a health maintenance organization.
Kentucky All Schedule Prescription Electronic Reporting System (KASPER)[2]	The Kentucky All Schedule Prescription Electronic Reporting System (KASPER) tracks controlled substance prescriptions dispensed within the state. A KASPER report shows all scheduled prescriptions for an individual over a specified time period, the prescriber and the dispenser.
Lock-In Recipient[3]	A recipient enrolled in the lock in program.
Lock-In Program[4]	The Kentucky Department of Medicaid Services Program which restricts an enrollee to receiving Medicaid services from a designated

[1] Lock-in Program Description CC052012211KYCM00088
[2] Lock-in Program Description CC052012211KYCM00088
[3] Lock-in Program Description CC052012211KYCM00088
[4] Lock-in Program Description CC052012211KYCM00088

	Primary Care Physician (known hereafter as PCP), pharmacy and/or hospital.
Poly-Prescriber / Polypharmacy/ Emergency Department Over Utilization Report[5]	A monthly report of all enrollees who received services within two (2) consecutive 180-day periods from at least five (5) different providers, and at least ten (10) different prescription drugs; and from at least three (3) or more different pharmacies or had at least four (4) hospital emergency department visits for a condition that was not an emergency medical condition or from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition.

LEGAL/CONTRACT REFERENCE:

- Kentucky Medicaid Managed Care Contract Section 32.10 Lock-In Program
- Lock-In Program Regulation 907 KAR 1:677
- Lock-In Program Description

FOCUS/DISPOSITION; Scope; Criteria for Inclusion in Lock-In Program[6] will be modified so that in addition to the existing provisions:

- A member may be placed in the Lock-In program if within two (2) consecutive 180-day periods the member:
  - Received services from at least five (5) different providers AND
  - Received at least ten (10) different prescription drug; AND
  - Received prescriptions from at least three (3) or more different pharmacies

  OR
  - Had at least four (4) hospital emergency department visits for a condition that was not an emergency medical condition;

  OR
  - Received services from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition.

FOCUS/DISPOSITION; Scope; Lock-In Program Exclusions[7] will be added in addition to the

[5] Lock-in Program Description CC052012211KYCM00088
[6] Lock-in Program Description CC052012211KYCM00088
[7] Lock-in Program Description CC052012211KYCM00088

existing provisions:

- Enrollees in personal care homes
- Enrollees under eighteen (18) years of age
- Enrollees receiving hospice services
- Enrollees receiving services through a home and community-based waiver program (these members are typically excluded from managed care)
- Enrollees who are awaiting transplants and being managed by a transplant case manager.
- Enrollees who are actively receiving treatment for cancer)
- Enrollees diagnosed with end stage renal disease; or
- Medicaid services utilized in a medically necessary manner to treat a complex, life-threatening medical condition, as determined by Aetna. [8]

FOCUS/DISPOSITION; Scope; Clinical Review[9] will be modified so that in addition to the existing provisions:

- Aetna Better Health's Lock-In Program is managed by Aetna Better Health's Care Management department and the Lock-In Committee.

FOCUS/DISPOSITION; Scope; Enrollment into Lock-In Program[10] will be added in addition to the existing provisions:

- Any enrollee that meets the above criteria will be enrolled into the Lock-In Program.
- A letter will be sent sixty (60) days prior to the lock in effective date to notify the enrollee and provide the contract required timeframe for the enrollee to appeal the lock-in status.

Responsibilities of the Lock-In Staff and the Lock-In Committee[11] will be modified so that in addition to the existing provisions:

- Lock-In Committee
  - The committee includes the manager of Clinical Health Services, social worker, RN case manager, pharmacist and medical director.[12]

[8] Lock-in Program Description CC052012211KYCM00088
[9] Lock-in Program Description CC052012211KYCM00088
[10] Lock-in Program Description CC052012211KYCM00088
[11] Lock-in Program Description CC052012211KYCM00088
[12] Lock-in Program Description CC052012211KYCM00088, page 3 "Lock-in Committee"

- The Lock-In Committee is responsible for the routine oversight of Aetna Better Health's Lock-In Program.
- The committee reports to the Compliance Committee, which reports to the Executive Quality Management Committee.

Notice of Restriction[13] will be modified so that in addition to the existing provisions:

- An enrollee receives a written notice telling him/her that he/she is being enrolled in the Lock-In Program. Enrollment in the Lock-In Program will not be effective until sixty (60) days from the date the enrollee is provided written notice.
- Aetna Better Health assigns a PCP/pharmacy and/or hospital. The PCP/pharmacy and or hospital will be reasonably close to the enrollee's home. The selection is for the entire period of the restriction unless the enrollee is approved for a PCP/provider/pharmacy/hospital change by Lock In staff.
- The written enrollee notice includes the following information:
    - Explanation of why he/she is being restricted
    - A description of the Lock-In Program
    - The effective date of enrollment in the Lock-In Program
    - Identification of the enrollee's designated provider/pharmacy/hospital
    - Information related to an enrollee's right to file a grievance with the MCO
    - How to contact Aetna Better Health with any questions
    - Offer of care management if the enrollee is not already enrolled
    - The right to file an appeal for a re-review in response to the decision
- An enrollee may request to change Aetna Better Health's designated PCP/pharmacy and/or hospital. An enrollee may not change a designated PCP/pharmacy and/or hospital more than once within a twenty-four (24)month period.
- If one (1) of the following happens, the change can be made for cause:
    - The enrollee is approved for a PCP/pharmacy and/or hospital change
    - The enrollee leaves the geographical area
    - The PCP/pharmacy and/or hospital leaves Aetna Better Health's provider panel
- The PCP/pharmacy and/or hospital inform Aetna Better Health they will no longer be the enrollee's assigned PCP.
- Aetna Better Health will decide if the requested change meets the criteria.

[13] Lock-in Program Description CC052012211KYCM00088

Enrollee's Right to file an Appeal[14] will be modified so that in addition to the existing provisions:

- The enrollee will have ten (10) calendar days from the date of the oral appeal to provide the request in writing.

Annual Lock-In (Restriction) Program Re-evaluation[15] will be modified so that in addition to the existing provisions:

- Aetna Better Health re-evaluates an enrollee's enrollment in the Lock-In Program after an enrollee's initial twenty-four (24) month lock in period and then annually (based on the date of enrollment into the program).
- If the enrollee continues to meet criteria, he/she will remain in the Lock-In Program.
- If the enrollee does not continue to meet criteria, he/she will be released from the Lock-In Program.

Terminating Lock-In (Member Restriction) [16] will be modified so that in addition to the existing provisions:

- In addition, criteria for termination includes enrollee have a significant change in health status
- In the event of an emergency, if an enrollee is locked into a pharmacy that does not have twenty-four (24) hour access or if, the pharmacy does not have the medication prescribed; a pharmacy will be temporarily "added" to allow access to that pharmacy.

Measurements[17] will be modified so that in addition to the existing provisions:

- Enrollee measurements (upon initial identification, referral, and re-evaluation):
  - Received services from at least five (5) different providers and
  - Received at least ten (10) different prescription drugs and
  - Received prescriptions from at least three (3) or more different pharmacies
  - Had at least four (4) hospital emergency department visits for a condition that was not an emergency medical condition; or
  - Received services from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition

INTER-/INTRA-DEPENDENCIES; Internal will be modified so that in addition to the existing

[14] Lock-in Program Description CC052012211KYCM00088
[15] Lock-in Program Description CC052012211KYCM00088
[16] Lock-in Program Description CC052012211KYCM00088
[17] Lock-in Program Description CC052012211KYCM00088

provisions:

- Lock-In Committee

INTER-/INTRA-DEPENDENCIES; External will be modified so that in addition to the existing provisions:

- Kentucky Department of Medicaid Services

This amendment will remain in effect until Aetna Better Health notifies Aetna Medicaid Policy Committee that it has been retired.

Aetna Better Health

Paige Mankovich
Chief Executive Officer

Madelyn Meyn, MD
Interim Chief Medical Officer

Review/Revision History	
01/2022	Implementation of AMA Policy Amendment Process for Member Restriction Program
03/2022	Addition of restriction definition. Updated CEO and CMO to reflect current leadership
03/2023	Annual Review. Minor edits to criteria for inclusion—adding AND and OR. Updated footnote for lock-in program exclusions. Updated health plan CMO.
03/2024	Annual review: Changed from provider to PCP. Grammar and formatting changes. Lock-In Program description reviewed as part of review and update of policy.

Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management - Plan**		**SUBJECT (Document Title)** **Lock-In - KY**	
Effective Date 08/12/2014	**Date of Last Review** 04/08/2024	**Date of Last Revision** 04/08/2024	**Dept. Approval Date** 04/08/2024
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☒ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Blue Cross and Blue Shield KY Medicaid (Anthem) has developed a program to address and contain Enrollee over utilization of services, for pharmacy and non-emergent care provided in an emergency setting. The Department for Medicaid Services will ensure that the Single MCO PBM provides the necessary support required for Anthem Blue Cross Blue Shield, KY Medicaid (Anthem) to administer the lock-in program.

Any Anthem Blue Cross and Blue Shield KY Medicaid (Anthem) Member meeting the utilization of healthcare services criteria indicated below is subject to the Plan Lock-In Program, whereby the Member is restricted to receiving healthcare services from assigned providers. These providers may include Primary Care Provider (PCP), Controlled Drug Prescriber (CDP), a Pharmacy, and/or a Hospital for non-emergency care.

1) Criteria for identification and enrollment of an Enrollee in the lock in program.
    a) New Enrollees restricted under a prior MCO's Lock-In program, where the restriction period for covered services has not yet expired. Anthem will apply the imposed restrictions on the Enrollee's effective date or as soon as the restriction is communicated to Anthem (Anthem). The restriction will remain in place for at least twenty-four (24) months from initiation of the original Lock-In. Anthem will inform the Member and the designated provider(s), in writing, of the ongoing restriction(s). At the time the initial Lock-In period expires, Anthem will reevaluate the Member's claim data to determine if the Lock-In can be released or if Lock-In criteria are still met, to recommend that the Enrollee continue to be enrolled in the Lock-In program.
    b) Any non-exempt Enrollee who meets the criteria for enrollment in the Lock-In program.

2) Enrollee's exempt from the Lock-In restrictions include:
    a) Enrollees residing in a facility reimbursed pursuant to 907 KAR 1:025 or 1:065 (such as a nursing facility or group home) or personal care home.
    b) Enrollees under the age of eighteen (18) years.

c) Enrollees receiving services through a home and community based waiver program in accordance with 907 KAR 1:145, 1:160, 1:595, 1:835, 3:090, or 3:210.
d) Enrollees receiving hospice services in accordance with 907 KAR 1:330.
e) Enrollees who have utilized healthcare services at a frequency or amount which was medically necessary to treat a complex, life threatening medical condition, as determined by (Anthem).
f) Enrollees for whom the Plan has determined enrollment in the Lock-In program is not in the Members' best interest.

3) Data for Lock-In review is collected and analyzed by a designated RN Case Manager (CM) or manager on at least a monthly basis from the following:
   a) MCO Member Lock-In Report provided to the Plan by Kentucky Department for Medicaid Services (DMS) monthly;
   b) Enrollee health and pharmacy claims data;
   c) Monthly Emergency Room utilization report;
   d) DMS Nonemergency ER code list

4) (Anthem) will initiate Lock-In if in two (2) consecutive 180 calendar day periods, the Member:
   a) Received services from at least five (5) different providers;
   b) Received at least ten (10) different prescription drugs; *and*
   c) Received prescriptions from at least three (3) or more different pharmacies; and/*or*
   d) Had at least four (4) hospital emergency department (ED) visits for a condition that was not an emergency medical condition; *or*
   e) Received services from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition.

5) The Lock-In Member will be restricted to receiving healthcare services from designated providers, which may include:
   a) 1 PCP, and
   b) 1 controlled substance prescriber, and
   c) 1 pharmacy; and/or
   d) 1 hospital for nonemergency care

6) At no time will (Anthem) restrict an Enrollees access to Emergency Services or to a specific provider of Emergency Services or deny coverage of Emergency Services for a restricted Member.

DEFINITIONS:

Fraud: an intentional deception or misrepresentation made by a recipient or a provider with the knowledge that the deception could result in some unauthorized benefit to the recipient or provider or to some other person. It includes any act that constitutes fraud under applicable federal or state law (KRS 205.8451).

Lock-In program: a Medicaid MCO program which restricts a Member to receiving healthcare services from designated providers.

Non-emergency care: a service for a nonemergency condition

Overutilization: the receipt of a treatment, drug, medical supply, or other service from one (1) or more providers in an amount, duration, or scope that exceeds the amount that would reasonably be expected to result in a medical or health benefit to the Member.

Prescriber: means a health care professional who:

a) Within the scope of practice under Kentucky licensing laws, has the legal authority to write or order a prescription for the drug that is ordered;
b) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672;
c) Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and
d) Prescribes in accordance with his or her current registration with the U.S. Department of Justice's Drug Enforcement Administration.

Primary care provider (PCP): a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse, physician assistant, or health clinic, including an FQHC, primary care center, or Rural Health Clinic (RHC) that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to individuals, and for a Member who has a gynecological or obstetrical health care needs, disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care.

Provider: any person or entity under contract with Anthem or Anthem's contracted agent that provides Covered Services to Members.

Utilization review: (Anthem's) review and analysis:

a) Of Member claims for a twelve (12) consecutive month period including:
    1) A Member's medical conditions; and
    2) Services received by the Member.
b) To determine if recipient overutilization has occurred.

Section (Primary Department)	SUBJECT (Document Title)
Health Care Management - Plan	Lock-In - KY

PROCEDURE:

1) When an Enrollee is newly identified as meeting one or more of the criteria for Lock-In, their utilization data and all supporting documentation will be reviewed by the designated CM or manager. The CM/manager will determine if the Enrollee's utilization of providers, prescriptions, pharmacies, and ED meets the requirements for restriction(s) and recommend Lock-in and/or appropriate supportive services such as case management, disease management or other available clinical programs.

   If fraud, provider abuse, or recipient abuse is identified in the course of a health plan utilization review for lock-in purposes, the health plan shall comply with KRS 205.8453(3).

2) If the CM/manager concludes the Enrollee's utilization of services requires restriction, the following procedures will occur:
   a) A written summary of the specific reason(s) for a restriction is prepared, including claims data and any supportive documentation, as well as the corresponding criteria for restriction.
   b) The summary, all supporting documents and completed Lock-In determination form is presented to the Lock-In review group by the Health Care Management (HCM) Manager or designated CM to the Plan Medical Director and the Regional or Local Pharmacy Director. This review group meets monthly to review and make determinations regarding new and annual Lock-In recommendations.
   c) If the decision of the Plan Medical Director is not to place the Enrollee in the Lock-In program, the Enrollee will be referred to any of the appropriate supportive services such as case management, disease management or other available clinical programs.
   d) If the decision of the Plan Medical Director is to place the Enrollee in the Lock-In program, the Enrollee will be notified in writing. An initial placement Lock-In letter is sent to the Enrollee via First Class mail no later than thirty (30) days prior to the effective Lock-In date.
      i. The notice will contain the following information:
         1) The reason for enrollment in the Lock-In program
         2) A description of the Lock-In program
         3) The effective date of Lock-In program enrollment
         4) Identification of member's designated providers
         5) Contact information of who to contact in writing or by phone for information related to the Lock-In program.
         6) How the member is granted the opportunity to appeal being placed in the Lock-In program in accordance with the:

a. MCO internal appeal process requirements established in 907 KAR 17:010 Section 4; and
b. The department's state fair hearing requirements established in 907 KAR 17:010.

e) Designated providers will be informed of their responsibilities for providing care to a restricted member via an initial placement provider Lock-In letter. The provider notice includes:
   i. Identification of the Enrollee being restricted
   ii. The reason for the Enrollee's enrollment in the Lock-In program
   iii. Identification of the Enrollee's designated provider(s);
   iv. The effective date of Lock-In program enrollment
   v. The provider's management responsibilities;
   vi. A summary of the Lock-In program and what this means for the Enrollee that has been restricted.

   When a pharmacy restriction has been imposed, the pharmacy is able to review the restriction via pharmacy claims system.

3) The Enrollee's initial restriction will remain in place for twenty-four (24) months regardless of whether the Enrollee changes MCOs and reviewed annually thereafter.

4) The Enrollee may request a change of a designated provider once within the twenty-four (24) month Lock-In period or for good cause as defined in 907 KAR 1:677. If a change in assignment occurs, written notification of the change will be sent to the enrollee and designated providers.

5) When a restriction has been imposed, the Enrollee will only be allowed to access covered services from Health Plan-designated Lock-In providers, except in the case of emergencies or if the Enrollee has been referred to an alternate provider authorized by Anthem and the PCP. The Enrollee is allowed to access services from providers who are covering for the Lock-In provider(s) or providers who were referred by their Lock-In provider via the Lock-In Provider Referral Form.

6) The designated PCP must:
   a) Be accessible to the Enrollee within (Anthem)'s time and distance standards for provider access.
   b) Provide services and manage the Lock-In recipient's necessary health care services.
   c) Complete and forward a Lock-In Provider Referral Form to a specialist and Anthem if the Lock-In Enrollee needs to see a specialist.
   d) If the designated PCP is a physician, may serve as the Lock-In recipient's designated controlled substance prescriber.

7) During the administration of the program, Anthem will work with the Enrollee and their provider to provide care management and education reinforcement as necessary. The CM nurse will educate Members regarding (as applicable):
    a) appropriate pharmacy utilization,
    b) emergency department utilization,
    c) risks of the pattern of use of current medications,
    d) coordination of care among physicians,
    e) the importance of regular medication renewal, and
    f) the importance of complying with provider visits and established treatment plan.
    g) the availability and process for accessing mental health and substance use services.

8) The -Enrollee's restriction status will be reviewed thirty (30) days prior to the end of the twenty-four (24) month restriction period to determine whether an additional restriction period is appropriate. Upon review, Anthem will determine if the Member's actions continue to meet criteria for restriction as outlined in this policy.
    a) An Enrollee restricted for an additional period will be informed in writing that the restriction(s) will continue and for what period of time. Written notification is also sent to the designated provider(s) and the claims payment system Lock-In end date is updated.
    An Enrollee restricted for an additional period will have the same appeal rights and is entitled to all appropriate notices informing him/her of the proposed action as indicated in the above sections.
    b) An Enrollee released from Lock-In will be informed in writing of the date that their restriction will end. The member's designated provider(s) will be copied on this written notice and the claims payment system Lock-In end date is updated.

9) In accordance with 907 KAR 17:020 (Section 6 2b), Lock-in Members may appeal a restriction decision by submitting an appeal in writing or orally to Anthem within 60 days from the original notice in accordance with Anthem's internal appeal process established under 907 KAR 17:010.

10) If the Enrollee is dissatisfied with the Appeal decision by the Plan, they may request a State Fair Hearing within 120 days of the final appeal notice by following the process established in 907 KAR 17:010.

11) Outcomes will be tracked for the program and findings will be utilized to adjust the program and Enrollee supports as needed.

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management - Plan	**Lock-In - KY**

REFERENCES:

- 907 KAR 1:563. Medicaid covered services hearings and appeals
- 907 KAR 1:677. Medicaid recipient Lock-In program
- 907 KAR 17:010. State Fair Hearing Requirements
- 907 KAR 17:020 Managed care organization service and service requirements and policies.
- Lock-In Program DTP
- Managed Care Contract 30.10 Lock-In Program

RESPONSIBLE DEPARTMENTS:

Primary Department: Health Care Management - Plan

Secondary Department(s): None

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
09/16/2015	• Annual Review/Transferred to MBU template
12/23/2015	• Off-cycle edits to health care services and PCPs
08/22/2016	• Annual review – minor wordsmithing
09/26/2017	• For annual review • Procedure and Reference sections updated
07/16/2018	• Early annual review • Policy completely rewritten to reflect current contract language
07/03/2019	• Annual Review • Change to pharmacy claim data language
06/16/2020	• Annual review – no changes
06/17/2021	• Annual review • Removed Pharmacy as a secondary department
05/20/2022	• Annual Review • Policy and Procedure sections updated - Changed Member to Enrollee, and Added Contract language • Updated References
05/03/2023	• Annual Review • Policy and Definitions sections updated – added Anthem due to

Review Date	Changes
	health plan rebranding • Updated References
04/08/2024	• Annual Review • Updated Procedure and References sections • Verified Regulations

Humana's Procedure for Pharmacy Restriction of Kentucky Medicaid Enrollees

Humana Policy, Standard, and Procedure

Creation Date:	April 24, 2019	**Accountable Dept:**	Humana Pharmacy
Publication Date:		**Business Domain:**	15 Pharmacy Solutions
Last Review Date:	January 19, 2024	**Business Area:**	15.05 Member Waste and Abuse

Summary of Changes:

Scope:

Statement:

Definitions:

Related Documents:

Standard:

Purpose:

Scope:

Requirement:

Definitions:

Related Documents:

Procedure:

Description: **This document provides an overview of the HUMANA process for restriction of Medicaid enrollees to a particular pharmacy for all medication services. The restriction is placed for enrollee safety due to excessive use of prescription drugs.**

Narrative: *OVERVIEW*

Enrollees may be reviewed for the Humana lock-in program from internal or external referrals as well as data mining of pharmacy and medical claims data to identify recipients who have an excess of medication fills.

When Humana receives a referral on an enrollee with an allegation of potential prescription drug abuse, a thorough review is conducted. Prior to completing the pharmacy restriction process, Humana will conduct a review on the enrollee and determine if the enrollee should be restricted to a particular pharmacy.

Review prior to restriction may include phone calls to enrollees and providers.

There is a minimum selection criterion that must be met in order to restrict a Kentucky Medicaid enrollee to one particular pharmacy. One of the following criteria must be met:

- Obtained three or more controlled substance prescriptions from three or more pharmacies written by three or more different prescribers within 180 days.
- Recipients who have been convicted of fraud through unauthorized sale or transfer of a pharmaceutical product funded by Medicaid.
- Utilized more than ten different controlled substance prescribers in 90 days.
- Obtained two or more controlled substance prescriptions written by two or more different prescribers who have utilized two or more pharmacies within 180 days *AND* have a documented diagnosis of narcotic poisoning or drug abuse within the last 365 days.
- Violated a pain management agreement/contract with their prescriber

Excluded recipients include sickle cell and oncology patients, recipients residing in institutionalized settings, recipients enrolled with Medicare and an enrollee of the state guardianship program.

Exception: This limitation does not apply to emergency services and care provided to the recipient in a hospital emergency department.

PROCEDURE

The following procedure is followed by Humana associates when the determination has been made to restrict a Kentucky Medicaid enrollee to a particular pharmacy.

Action

1. Potential enrollees who meet criteria are identified monthly by internal data mining. Claims history is reviewed to identify if enrollees meet criteria. Enrollees are reviewed to determine eligibility for enrollment
2. If enrollee is found to meet enrollment criteria, then Humana associate selects a pharmacy to which enrollee will be restricted.

   Pharmacies will be considered based on the following:
   - Current pharmacies used by the enrollee
   - Geographic location to the enrollee and/or the prescriber
   - Access to pharmacy services
   - Review pharmacy for in network status.
   - Preferred chain pharmacy
   - Must choose one location

3. Humana associate contacts the selected pharmacy and verifies the pharmacy will accept the enrollee for the lock-in, and monitor the enrollees' prescription fills for safety and overutilization.

4. Humana associate sends notification in writing of the restriction to the enrollee 30 calendar days prior to restriction to include:
   - Explanation of the lock-in program
   - Selected pharmacy(ies)
   - Request to change pharmacy
   - Notice of right to Medicaid fair hearing

   If the enrollee wishes to use another pharmacy provider, they must complete and submit the request on the Request for Reconsideration form attached to the notification letter by Humana. If enrollee selects a different pharmacy, the enrollee will be notified in writing of the outcome within 7 days of receipt of the request. Request to change pharmacy can be made at any time by completing the Pharmacy Change Request form attached to the original letter. All requests are reviewed for just cause prior to making determination.

5. Notification is sent in writing to the prescriber (PCP) and pharmacy 10 days prior to the implementation of the lock-in period.

6. Enrollee claim history is reviewed to determine if there is a specialty pharmacy in use. If identified, then this secondary pharmacy will be added as a lock-in pharmacy during initial enrollment.

   Enrollee claim history is reviewed to determine if enrollee is obtaining prescription for either Sublocade or Vivitrol. If so, then clinical review will be performed by pharmacist prior to approval of addition of specialty (secondary) pharmacy. Pharmacist will review claims information to determine if any clinical concerns are present. Reviewed criteria is listed below:
   - Sublocade:
     - Review pharmacy claims for the following:
       - A claim for an oral sublingual/transmucosal buprenorphine product equivalent at a 8mg to 24mg per day dose for at least 7 days prior to initiation of Sublocade

- Concurrent use of buprenorphine and benzodiazepines or other CNS depressants. Thisincreases the risk of adverse reactions including overdose, respiratory depression, and death when used with Sublocade.
- Review Sublocade dosing to ensure it is in accordance with guidelines
    - 300mg subcutaneously monthly for the first 2 months
    - Maintenance dose of 100mg or 300mg monthly

- Vivitrol:
    - Review of medical claims data for a diagnosis of acute hepatitis or liver failure.
    - Review of pharmacy claims for concurrent use of an opioid containing product.
        - Patient should be opioid free from 7-10 days prior to initiation
        - Patients transitioning from buprenorphine or methadone may be vulnerable to precipitation of withdrawal symptoms for as long as two weeks
    - Review Vivitrol dosing to ensure it is appropriate
        - The recommended dose of Vivitrol is 380mg delivered intramuscularly every 4 weeks or once a month

If any clinical concerns are found by the reviewing pharmacist, both the provider and pharmacy will be notified. A call will first be made to the pharmacy to discuss and document the concerns, prior to engaging them as a provider in the lock-in program. If a specialty (secondary) pharmacy calls the clinical team after the initial limitation is placed, the same process will be followed. A phone call will also be placed to the provider issuing the prescription to discuss findings. A follow up clinical review may be necessary during the 90 day review.

7. Recipients may request a Medicaid fair hearing within 120 days of the date of the notification letter of assignment into the lock-in program.

8. Referrals will be made to case management for review of enrollees' utilization for possible outreach.

9. Enrollee is placed on restriction for 12 months.

enrollee

10. Enrollees are reviewed every 90 days to ensure the lock is working appropriately. Claims history is reviewed to determine if enrollee has started utilizing a specialty pharmacy. If identified, then this secondary pharmacy will be added as a lock-in pharmacy.

    Enrollee claim history is reviewed to determine if enrollee is obtaining a prescription for either Sublocade or Vivitrol. If so, then clinical review will be performed by pharmacist prior to approval of addition of specialty (secondary) pharmacyA pharmacist will review claims information to determine if any clinical concerns are present. Reviewed criteria is listed below:
    - Sublocade:
        - Review pharmacy claims for the following:
            - A claim for an oral sublingual/transmucosal buprenorphine product equivalent at a 8mg to 24mg per day dose for at least 7 days prior to initiation of Sublocade
            - Concurrent use of buprenorphine and benzodiazepines or other CNS depressants. These increases the risk of adverse reactions including overdose, respiratory depression, and death when used with Sublocade.
            - Review Sublocade dosing to ensure it is in accordance with guidelines
                - 300mg subcutaneously monthly for the first 2 months
                - Maintenance dose of 100mg or 300mg monthly
    - Vivitrol:
        - Review of medical claims data for a diagnosis of acute hepatitis or liver failure.
        - Review of pharmacy claims for concurrent use of an opioid containing product.
            - Patient should be opioid free from 7-10 days prior to initiation
            - Patients transitioning from buprenorphine or methadone may be vulnerable to precipitation of withdrawal symptoms for as long as two weeks
        - Review Vivitrol dosing to ensure it is appropriate
            - The recommended dose of Vivitrol is 380mg delivered intramuscularly every 4 weeks or once a month

    If any clinical concerns are found by the reviewing pharmacist, both the provider and pharmacy will be notified. A call will first be made to the pharmacy to discuss and document the concerns, prior to engaging them as a provider in the lock-in program. If a specialty (secondary) pharmacy calls the clinical team after the initial limitation is placed, the same process will be followed. A phone call will also be placed to the provider issuing the prescription to discuss findings. A follow up clinical review may be necessary during 90 day review.

11. Once the restriction has been lifted, enrollee is placed on a 6 month follow up for review of prescription history to determine if the lock-in should be reinstated for an additional period of 24 months. The same notification process and hearing rights must be provided to the enrollee.

12. One time exceptions may be granted in situations where Humana is notified that the restricted pharmacy does not have medication to fill a prescription. Humana will verify with the restricted pharmacy that they are unable to fill the medication prior to allowing a one-time fill at another pharmacy. Humana will verify with a new pharmacy that they are able to fill the medication and direct the enrollee to that pharmacy. System will be set up to allow the one time exception fill.

Definitions: N/A

Related Documents: N/A

Owner:	Gabriela Phasley	**Executive Team Member:**	Melissa Perraut
Accountable VP / Director:	Jace Larkin		

Disclaimer:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by a particular issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/standard) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/standard) supersedes all other policies, standards, guidelines, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained in Policy Source to ensure no modifications have been made.

Non-Compliance:

Failure to comply with any part of Humana's policies, standards, guidelines, and procedures may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over any and all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Policy Source site of Humana's secure intranet on HI! (Sites/View Full Site Directory/Tools and Resources/Policy Source).

Passport by Molina Healthcare
Healthcare Services
Coordinated Services (Lock-In) Program

TABLE OF CONTENTS

HEALTHCARE SERVICES COORDINATED SERVICES (LOCK-IN) PROGRAM DESCRIPTION

The Coordinated Services Program (CSP) is designed to address the unique needs of those members who have demonstrated:

- prescription misuse or behaviors that may represent a danger to the member or;
- behavior that may indicate substance misuse or medication divergence or;
- service over-utilization by receiving services that are not medically necessary or;
- fraudulent or abusive patterns of service utilization

The goal of the program is to prevent death or injury from the unsafe use of prescription drugs and to prevent Medicaid fraud, waste, or abuse. This program is intended to create an avenue for substance misusers or overutilizers of high cost settings and/or services to change their behavior by providing guidance through care management, making available community resources and substance use disorder specialists, carefully monitoring prescription use and/or utilization and assigning the member a single provider/setting for all care needs of a certain type, such as pharmacy.

A multidisciplinary care team (MCT) comprised of staff from Passport by Molina Healthcare (Passport) Medical Affairs and Health Care Services (HCS) Departments will have primary responsibility for the administration and oversight of the CSP program. These team members may include physicians, pharmacists, registered nurses, behavioral health professionals, and other allied health professionals.

The CSP program is broadly defined by four key components: (a) identification and evaluation, (b) notification, (c) enrollment, and (d) reassessment for continued enrollment. Identification and evaluation refers to the process of:

- Identifying members as potential candidates for the program based on analysis of pharmacy and utilization data.
- Screening the results for members whose utilization patterns could be reasonably expected based on their clinical condition.
- Evaluating the remaining members to identify those who are most appropriate for the program.

Participants of the MCT will oversee the analysis and will evaluate potential candidates prior to enrollment in the lock-in program.

The following members are excluded from the CSP:

- Members residing in a personal care home
- Members under the age of 19
- Members receiving hospice services
- Members who are Medicare recipients
- Members who are Indians of a federally recognized tribe

When there are changes made to the Coordinated Services Program, Passport will resubmit this program description to the department of medicaid services for approval.

CRITERIA FOR PROGRAM ENROLLMENT

PHARMACY/PRESCRIBER ENROLLMENT CRITERIA

1. Individuals who meet any of the following criteria during two consecutive 180 calendar day periods will be evaluated for enrollment in the program:
    a. Individual received four or more high-risk medications or;
    b. Individual obtained prescriptions for high-risk medications from five or more prescribers or;
    c. Individual had a poisoning overdose with a benzodiazepine, prescription opioid, or other high-risk medication; or
    d. Individual utilized three or more pharmacy locations for high-risk medications or;
    e. Individual received a concurrent prescription of opioids and benzodiazepines or stimulants.
2. Individuals who meet any of the criteria below will be automatically enrolled (not requiring MCT review).
    a. Have at least 3 of the criteria above under item 1 or;
    b. Have a history of substance use disorder and have at least 2 of the criteria above under item 1 or;
    c. Received one narcotic analgesic, and one benzodiazepine, and one stimulant or muscle relaxant within a 30-day period.

HOSPITAL EMERGENCY DEPARTMENT ENROLLMENT CRITERIA

1. Individuals who meet ~~all~~ one of the following criteria during two consecutive 180 calendar day periods will be evaluated for enrollment in the program:
    a. Had 4 or more Emergency Department (ED) visits for a condition that was not an emergency medical condition.
    b. Received services from at least 3 different ED locations for a condition that was not an emergency medical condition.

PHARMACY/PRESCRIBER CSP PROCESS

IDENTIFICATION AND EVALUATION

1. Members are identified for evaluation based on the Pharmacy utilization report.
    a. MCT runs the report on a monthly basis
2. Potentially eligible members are assigned to a CSP Case Manager or other MCT member for review of utilization

3. Members may be referred to non-CSP care management (CM) after the review is complete or members may remain with CSP if CSP is recommended.
    a. The assigned Case Manager educates member about medication safety and appropriate utilization of services, addresses barriers to accessing care in the appropriate setting, and informs the member about enrollment into the CSP (if applicable).
4. If the **clinical** review identifies that serious/chronic health conditions are a contributing factor to the member's utilization, and the decision is made not to enroll in CSP based on the contributing factors and agreement by the MCT, the member is referred to Complex CM (Level III CM) for management and education.
5. If utilization patterns continue, the general Case Manager may refer the member to CSP regardless of engagement in Complex CM. If a member is enrolled in CSP, the case will transfer to a CSP Case Manager.

ENROLLMENT AND NOTIFICATION

1. If member meets criteria for automatic enrollment, step 2 is skipped.
2. If review of member's current and/or recent utilization indicates member is appropriate for the program the CSP CM initiates member enrollment into the CSP program. If review indicates member doesn't meet criteria, CSP Case Manager provides the completed CSP Review form to the MCT for review and approval.
3. Review will include all pharmacy and ED utilization. If MCT agrees/approvesCSP, the approval may include:
    a. Lock the member in to a pharmacy and controlled substance prescriber(s)
    b. Do not lock the member in

2. When a member is locked in:
    a. CSP Case Manager contacts the PCP to make them aware of CSP enrollment for the member and educate on the CSP program
    b. CSP Case Manager notifies member of CSP enrollment and appeal rights and assists member in selecting a designated pharmacy and prescriber(s)
        i. If contact is made with the member, a Health Risk Assessment (HRA), comprehensive needs assessment, and care plan development is attempted by the CSP Case Manager.
    c. CSP Case Manager adds Pharmacy & Prescriber Restrictions in MedImpact system and Lock In Pharmacy & Provider information into QNXT.
        i. If no successful contact is made with the member, CM will use the most recent pharmacy and prescriber for the MedImpact Restrictions
    d. CSP Case Manager contacts members at the appropriate cadence and creates case notes per established protocols.
        i. Members who are actively engaged in the program (working on care plan goals) are contacted at least monthly until they successfully meet care plan goals, become unable to be contacted, decline further participation or are released from the CSP program.
        ii. Members who are unable to be contacted (UTC) will be attempted via a full UTC process at least once every 6 months until they are reached and engaged in the program, they

are reached and decline participation, or they are released from the program. The case manager will document member's utilization at least every 6 months.

iii. Members who decline to participate in CM will not be contacted again unless typical CM processes warrant another engagement attempt (e.g., if there is a change in health status, the member calls in to request assistance, etc.). The case manager will document member's utilization at least once every 6 months.

1. Members can decline to participate in CM, however, restrictions/locks are still put in place.

d. If a member who previously declined to participate or was UTC is engaged at any point then monthly follow up will resume.

REASSESSMENT FOR CONTINUED ENROLLMENT

1. The CSP Case Manager reevaluates the CSP status based on member behavior/utilization at 24 months for a new lock(s)
    a. 60 days prior to the end of initial 24-month term, the CSP Case Manager performs the review of member's behavior/utilization and completes the CSP Review form for submission to the MCT.
    b. The MCT determines whether member is released from CSP or will continue in CSP. MCT must at a minimum include a Medical Director.

2. If member continues in CSP, the period is for an additional 12 months. Regardless of member's current engagement status, the case manager will attempt outreach and, if necessary, will complete a full UTC process to notify the member of the 12-month program extension. The PCP will be notified of the member's 12-month program extension.
    a. 30 days prior to the end of the 12-month term, the CSP Case Manager performs the review of members behavior/utilization and completes the CSP Review form for submission to the MCT.
    b. The MCT determines whether the member is released from CSP or will continue in CSP. MCT must at minimum include a Medical Director.
    c. Subsequent uninterrupted CSP enrollment is evaluated every 12 months.
3. If member no longer meets criteria, they are disenrolled from CSP. If continued CM is needed for chronic conditions, the CSP Case Manager transfers the member to general CM.
4. Starting six (6) months after release from CSP, a member will be included in system reports for pharmacy utilization behaviors and potential enrollment in CSP. If a member is identified as being appropriate again for CSP a new lock set can occur that will last 24 months.

RESTRICTION EDITS AND LOST/ STOLEN MEDICATIONS

1. MedImpact Restriction edits will be performed/decided by the CSP CM team.
    a. Restriction edits are allowed if:
        i. Member is out of town
        ii. CSP designated pharmacy is out of the member's medicine

iii. Member relocates or becomes unable to continue with the designated prescriber(s) or pharmacy.

b. If the CSP Pharmacy confirms medications are not in stock:
   i. A 30 day supply can be filled at a pharmacy of the member's choice if a restriction edit has been performed.

a. If a member's medication is stolen:
   i. This situation requires a valid police report be sent to Passport in one of the following ways:
      1. emailed to: CareManagement_KY@molinahealthcare.com
      2. faxed to: 800-983-9160
   ii. The report will then be forwarded to MedImpact for review.
   iii. Prior Authorization (PA) may still be required with MedImpact from the Prescriber.
   iv. MedImpact overrides for lost or stolen medications are limited to one (1) occurrence per year and can only be performed by MedImpact staff.

2. Changes in Prescriber during enrollment in CSP are allowed for the following reasons:
   a. Prescriber does not want to serve the member
   b. Prescriber has closed or moved to another site not convenient to the member
   c. Prescriber has been suspended/excluded/terminated/disqualified from Medicaid
   d. Member has moved beyond 30 min/miles from the prescriber
   e. Any other reason considered to be good cause by Passport/Law/Regulation

HOSPITAL EMERGENCY DEPARTMENT CSP PROCESS

IDENTIFICATION AND EVALUATION

1. Member identified based on emergency department(ED) utilization report
   a. MCT runs the report on at least a monthly basis
2. Potentially eligible members are assigned to a CSP Case Manager for review of their utilization
3. The member may be referred to non-CSP CM after the review is complete if the member doesn't meet criteria for enrollment in hospital emergency department CSP
   a. The assigned case manager educates member about appropriate utilization of services, addresses barriers to accessing care in the appropriate setting, and informs the member about potential enrollment into the lock-in program
   b. Members are provided with resources such as:
      1. Where to Go For Care Brochure
      2. A list of their local urgent/immediate care centers
      3. Information about Teladoc services

5. If member's ED usage is related to unstable management of conditions, the member is referred to Complex CM.

ENROLLMENT AND NOTIFICATION

1. The CSP Case Manager uses **clinical** judgment when recommending that a member be enrolled in CSP.

a. CSP Case Manager completes CSP Review form and sends the form to the MCT for review and approval (review will include all ED and pharmacy utilization)
b. MCT determinations may include:
    i. Lock the member in
    ii. Do not lock the member in

3. When a member is locked in:

a. CSP Case Manager contacts the PCP to make them aware of the CSP enrollment for the member and educate on the CSP.

b. CSP Case Manager notifies member of CSP enrollment & appeal rights and assists member in selecting a designated ED. CSP Case Manager updates lock-in information in QNXT.

c. If contact is made with the member, a Health Risk Assessment (HRA), comprehensive needs assessment, and care plan development is attempted by the CSP Case Manager.

d. If no successful contact is made with the member, CM will use the most recent and frequent ED for the QNXT Lock In information.

e. CSP Case Manager contacts members at the appropriate cadence and creates case notes per established protocols.

i. Members who are actively engaged in the program (working on care plan goals) are contacted at least monthly until they are released from the program, decline further participation or become unable to be contacted.
ii. Members who are unable to be contacted (UTC) will be attempted via a full UTC process at least once every 6 months until they are reached and engaged in the program, they are reached and decline participation, or they are released from the program. The case manager will document member's utilization when outreach is attempted.
iii. Members who decline to participate in CM will not be contacted again unless typical CM processes warrant another engagement attempt (e.g., if there is a change in health status, member calls CM for assistance, etc.). The case manager will complete and document a review of member's utilization at least once every 6 months.

REASSESSMENT FOR CONTINUED ENROLLMENT

1. The CSP Case Manager reevaluates CSP status based on member's utilization at 24 months for new locks.
    a. 60 days prior to end of 24-month term, the CSP Case Manager completes the review of member's utilization and completes the Lock-In Review form for submission to the MCT.
    b. The MCT determines whether member is released from lock-in or will continue in lock-in. MCT must at a minimum include a Medical Director
2. If member continues in CSP, the period is for an additional 12 months. Regardless of member's current engagement status, the case manager will attempt outreach and, if necessary will complete a full UTC process, to notify the member of the 12-month program extension. The PCP will be notified of the member's 12-month program extension.
    a. 30 days prior to the end of the 12-month term, the CSP Case Manager performs the review of members behavior/utilization and completes the CSP Review form for submission to the MCT.

b. The MCT determines whether the member is released from CSP or will continue in CSP. The MCT must at minimum include a Medical Director.
c. Subsequent uninterrupted CSP enrollment is evaluated every 12 months.

3. If member no longer meets criteria, they are released from CSP. If continued CM is needed for chronic conditions, the CSP Case Manager transfers the case to general CM.
4. Starting six (6) months after release from CSP, a member will be included in system reports for ED utilization behaviors and potential enrollment in CSP. If a member is identified as being appropriate again for CSP a new lock set(s) can occur that will last 24 months.

OVERRIDES AND EMERGENCIES

1. System lock edits:
   a. System lock edits are allowed if:
      i. The member is out of town
      ii. The member moved
      iii. Urgent Care is unable to provide the needed care
2. Changes in designated CSP ED during CSP enrollment is allowed for the following reasons:
   a. Designated ED does not want to serve the member
   b. Facility has closed.
   c. Facility has been suspended/excluded/terminated/disqualified from Medicaid
   d. Member has moved beyond 30 min/miles from the facility
   e. Any other reason considered to be good cause by Passport/Law/Regulation

CHANGES TO CSP PHARMACY/PROVIDER/FACILITY

1. When a CSP pharmacy/provider/facility is changed:
   a. The CSP Case Manager or designee processes the request
      i. Passport CSP team makes necessary updates in -MedImpact system

2. Passport will provide Continuity of Care to a member in CSP member when their designated CSP provider leaves the Passport provider network in accordance with Policy and Procedure.

STANDARD APPEAL PROCESS

1. Standard Appeal Process:
   a. Member has the right to appeal the CSP enrollment decision within 60 days of the lock-in notification letter

DOCUMENTATION

1. Appeals must be initiated by the member requesting the appeal with Member Services.
2. Passport systems will be used to document and track member appeals
3. Passport staff will record the CSP enrollment period and providers by updating the applicable systems

4. Passport will maintain records for each individual review completed by the Case Manager/MCT. The records will include at a minimum:
    a. Relevant data collected supporting the lock-in
    b. Summary of the lock-in review and determination
    c. Evidence of abusive practice other than medical reasons
    d. Copy of the letter notifying member of the lock-in
    e. If member appeals:
        i. Copy of the action appeal
        ii. Any additional information presented during the appeal or fair hearing
    f. If CSP is decided against or discontinued:
        i. Specific rationale for the determination
    g. All interactions with the member and provider as well as any other resources accessed

TRAINING

1. Health Plan staff will be trained on the Cordinated Services Program.

REPORTING

1. Passport will report on the Program membership based on regulatory/contractual requirements at the requested frequency.
2. Some aspects of evaluating CSP may include:
    a. Costs (before and after lock-in)
        i. Pharmacy
        ii. Institutional (ED/Inpatient)
        iii. Professional (PCP/Specialists)
    b. Claims Count (before and after lock-in)
    c. Program Effectiveness
        i. Improved Member Outcomes
        ii. Decline Member Outcomes
        iii. Unchanged Member Outcomes

POLICY AND PROCEDURES

HCS-407 COC and Access to Care for New and Existing Members– Continuity of Care and Access to Care

UnitedHealthcare COMMUNITY & STATE

Local Health Plan: UnitedHealthcare Community Plan (UHCCP) of Kentucky			
Policy Information			
National Policy Title	C&S High Prescription Utilization Program	**Current Version Publish Date**	08/08/2023
Version	1.2	**Original Effective Date**	01/01/2021
Policy ID	ID-31884		
Policy Applicability			
Products Impacted	UnitedHealthcare Community & State Medicaid, CHIP, and DSNP		

Policy Statement and Purpose

UnitedHealthcare Community & State and the delegated pharmacy benefit manager (PBM) adhere to the Centers for Medicare & Medicaid Services (CMS) and State Medicaid requirements for administering a pharmacy restriction program for Members with high prescription utilization.

Policy Provisions

1. UnitedHealthcare Community & State, using pharmacy and medical claims data, identifies on a monthly basis (or quarterly basis where applicable), Members with potentially inappropriate patterns of medication utilization as defined below:

1.1. Identification criteria parameters within a specified time frame include one of the following:

- Number of targeted pharmacy claims (nine or more) and number of prescribers (three or more) and number of pharmacies (three or more) in previous 90 days.
- History of drug or alcohol poisoning in previous 180 days with utilization of more than one targeted pharmacy claim.

1.2. Exclusion criteria parameters include:

- Members with a cancer diagnosis on file within the previous 12 months
- Medicare or Dual Members
- Hospice Members
- Members receiving palliative care
- Members who are homeless

2. The Clinical Pharmacy Team reviews the pharmacy and medical claims history for identified Members to determine if they should be considered for the pharmacy restriction program. The list is sorted to isolate the top 30 Members based on the top number of prescription claims, the top number of prescribers, and the top number of pharmacies utilized, respectively. Any Member who was previously part of the program but meets criteria again is prioritized for additional restrictions.

2.1. A recommendation file for inclusion in the pharmacy restriction program is created and presented to the Pharmacy Account Manager, or designee, for approval on a quarterly basis (or a monthly basis where applicable).

3. The Pharmacy Account Manager, or designee, makes the final determination as to which Members recommended for the pharmacy restriction program are selected for inclusion within 14 days of receipt of the recommendations.

3.1. After the final determination is made, the approved list of Members is provided to the Clinical Pharmacy Team. If a determination is not made within 14 days, the Clinical Pharmacy Team proceeds with the pharmacy restriction process.

3.2. If a recommended Member is not chosen for restriction, the Pharmacy Account Manager, or designee, is responsible for providing

rational for not recommending enrollment into the program.

4. A written notification is sent to Members selected for inclusion in the pharmacy restriction program, via regular USPS, to advise the Member of the intent to restrict medication utilization to one pharmacy.

4.1. Mailings are suppressed for Members who do not have a valid address on file.

4.2. The Member may request an appeal (if allowed by the plan – refer to state-specific policy) of the decision to restrict.

4.3. UnitedHealthcare Community & State allows 30 days from the mailing of the notification letter (or other time frame required by the plan) to obtain a response from the Member regarding the choice of an assigned pharmacy.

4.4. If the Clinical Pharmacy Team does not receive a response from the Member after 30 days, the Member is assigned to the network pharmacy provider (based upon previous use and geographic location) listed in the notification letter.

5. The Member may request a network pharmacy change one time per year.

5.1. Additional Member requests for change must meet one of the following:

- For a permanent pharmacy change:
    - Member moves greater than 30 miles from pharmacy
    - Member has transportation barriers new pharmacy can mitigate (delivery, walking distance, public transportation accessibility, etc.)
    - Pharmacy business hours no longer work for Member
    - Pharmacy refuses to continue to fill medication
    - Pharmacy has consistent stock issues
    - Pharmacy closing/changing ownership
    - Pharmacy leaving UnitedHealthcare network
    - All other situations are reviewed on a case-by-case basis
- For a temporary or emergency override pharmacy change:
    - Restricted pharmacy is closed for the day
    - Member under the care of a facility (LTC)
    - Hospital/Emergency Department discharge with rationale why Member cannot use restricted pharmacy
    - Vacation overrides (health plan specific rules still apply)
    - Stock issues
    - Non-targeted medications are always eligible for override
    - Medication is on back order
    - DEA allocation issues
    - All other situations are reviewed on a case-by-case basis

6. The Clinical Pharmacy Team may notify the selected network pharmacy, target medication prescriber, and/or the Member's primary care physician (PCP) via letter based on plan requirements regarding the decision to include the Member in a pharmacy restriction program.

7. The Clinical Pharmacy Teams adds a user warning flag to the Member's profile in the medical eligibility system. This triggers a pop-up notification that indicates pharmacy restriction to Member Services when the Member's profile is accessed.

8. The Clinical Pharmacy Team enters the restriction into the pharmacy system to initiate the restriction process after the Member is notified of the intent to restrict medication utilization and is given the opportunity to appeal the decision (where applicable).

8.1. The Member is restricted to a single pharmacy for all medications, excluding specialty medications.

8.1.2. The restriction period is 12 months (or as required by the plan).

9. Prior to a pharmacy restriction term ending (or as required by the plan) the Clinical Pharmacy Team reviews the Member's utilization to determine if the Member's restriction should be extended. Recommendations are presented to the Pharmacy Account Manager, or

designee, to make the final determination.

9.1. The Clinical Pharmacy Team enters the extension into the pharmacy system & updates the user warning flag in the medical eligibility system. Where required, additional notification letters are sent to the Member via regular USPS service.

9.2. Mailings are suppressed for Members who do not have a valid address on file or if Members are not currently active on the plan.

9.3.Restriction extension criteria – Any one of the following:

- Number of targeted pharmacy claims (nine or more) in 90 days
- Number of targeted medication prescribers (three or more) in 90 days
- Number of targeted medication pharmacies (three or more) in 90 days
- History of drug or alcohol poisoning in previous 180 days with utilization of more than one targeted pharmacy claim
- Enrolled in the program due to confirmed Fraud/Waste/Abuse

9.4. Restriction ends as soon as possible if any of the following exclusionary criteria is met:

- Cancer diagnosis on file within the previous 12 months
- Medicare or Dual Members
- Hospice Members
- Members receiving palliative care
- Members who are homeless

10. The UnitedHealthcare Community & State Drug Utilization Review Committee reviews the summary of the Members chosen for inclusion in the pharmacy restriction program twice a year. The Pharmacy Account Manager, or designee, receives a quarterly summary to inform the health plan of the program's progress. The summary includes the following information for each health plan:

- Number of Members recommended for restriction
- Number of Members chosen for restriction
- Number of Members restricted outside of the national program
- Total number of Members restricted
- Number of Members re-reviewed prior to restriction ending and subsequent result
- Number of Members who were restricted and have disenrolled from the plan

11. All Member determinations are reported to the Pharmacy Account Manager on a quarterly basis (or monthly as required). All Members selected for inclusion in the pharmacy restriction program are documented using a tracking grid that identifies the following:

- Member's name, date of birth, and plan
- Date of restriction
- Restriction review date
- Date restriction is scheduled to end
- Applicable comments

12. Where applicable, the Pharmacy Account Manager, or designee, refers all Members identified for enrollment in the pharmacy restriction program to the appropriate health plan department (e.g., Behavioral Health Department, Fraud and Abuse Operations, Care Management, Health Services) for assignment to a behavioral health care manager.

13. Members identified as candidates for pharmacy restriction outside of the national process are communicated to the Clinical Pharmacy Team. If the Member does not meet criteria for pharmacy restriction, the Pharmacy Account Manager or Medical Director may use clinical judgement to determine if the Member should be included in the program.

Resources and Materials for this Policy	
State Contract Section Number and Section Title:	**32.10 Lock-In Program** The Contractor shall develop a program to address and contain Enrollee over utilization of services, for pharmacy and non-emergent care provided in an emergency setting. The program shall include:

	A. Criteria for identification and enrollment of an Enrollee in the lock-in program; B. Methods the Contractor will implement to support Enrollees to understand and access appropriate utilization of services, such as Care Coordination, care management and education; C. Methods the Contractor will implement to address Enrollees who refuse to participate in the lock-in program or to engage with the Contractor on identified support methods; D. Length of enrollment in the program and ongoing assessment process; E. Approach to tracking outcomes of the program and using findings to adjust the program and Enrollee supports as needed.
Clarification	The pharmacy lock in policy and program description policy is entitled: C&S High Prescription Utilization Program.
Related Internal or External Links	
Related Process Instructions / References	
Related Job Aids	
Related Process Maps	
Other Reference Links	
Attachments	
Business and Regulatory Requirements	
Description of Business / Regulatory Requirements	
Related Documents	

POLICY AND PROCEDURE

POLICY NAME: Pharmacy Lock-In Program Policy	**POLICY ID: C20-RX-022**
BUSINESS UNIT WellCare Health Plan	**FUNCTIONAL AREA: Pharmacy**
EFFECTIVE DATE: 08/29/2005	**PRODUCT(S): Medicaid**
REVIEWED/REVISED DATE: 9/1/2023	
REGULATOR MOST RECENT APPROVAL DATE(S): 9/7/2022, 5/14/2020, 2/7/2020, 8/21/2019, 7/29/2019, 10/17/2016, 10/19/2015, 2/20/2015, 4/21/2014, 1/15/2013, 6/15/2011, 2/1/2011, 6/2/2010, 3/1/2010, 10/27/2009	

POLICY STATEMENT:
This section should state the overarching purpose of creating this policy and give a high-level overview of the policy.

PURPOSE:
The purpose provides the prescribed method to follow. It includes who, what, when, where, and how steps are to be completed.

SCOPE:
This policy applies to Medicaid members of WellCare Health Plans in AZ, HI, KY

DEFINITIONS:
N/A

POLICY:
The Clinical Pharmacy Department of WellCare Health Plans, Inc. ("WellCare") established the Program to limit over-utilizing members to a single pharmacy for their controlled substance prescription medication needs. The Clinical Pharmacy Department analyzes and reviews its information systems and other sources to determine and identify members who meet the established criteria to be enrolled in the Program. Members who meet the criteria are assigned to the Program and to a specific pharmacy as well as a specific prescriber as deemed appropriate. All members who are enrolled in the program who meet criteria are referred to WellCare's Care Management Department for additional monitoring, education, and care management services.
Each member assigned to the Program has their status reviewed against the criteria at least annually. Members assigned to the Program can have their assigned pharmacy changed based on good cause criteria, including relocation or drug availability. The Clinical Pharmacy Department provides the appropriate reporting based on established criteria and schedules to all corporate and government entities regarding the status of the program and its enrollees.

- The criteria are based on recommendations from the state (see Procedure C20-RX-022-PR-001).

While in "Lock-In" status, the member is restricted to one pharmacy to obtain his/her prescriptions for a twelve (12), eighteen (18) or twenty-four (24) month period based on requirements of the state. The restriction is removed if, after review of the recipient's drug-usage profile, that restriction to the Program is no longer appropriate, based on state requirements.

PROCEDURE:
See C20-RX-022-PR-001 Pharmacy Lock-in Program Procedure

REFERENCES: C20-RX-022-PR-001

ATTACHMENTS: Addendum A: Kentucky
Addendum B: Arizona

ROLES & RESPONSIBILITIES: See C20-RX-022-PR-001 Pharmacy Lock-in Program Procedure

REGULATORY REPORTING REQUIREMENTS:
See Addendums

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Removed addendums for NY, FL	9/1/2023
New Policy Document	Updated Policy Formatting	9/1/2023

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.

State Addendum B:	Kentucky Medicaid
Policy Name:	Pharmacy Lock-In Program Policy
Policy Number:	C20-RX-022
State Approval Date:	N/A

Policy:

Pursuant to Kentucky Managed Care Organization (MCO) Contract Section 33.10, “Lock-In Program”, WellCare shall develop a program to address and contain Enrollee over utilization of services, for pharmacy and non-emergent care provided in an emergency setting. The criteria for this program shall be submitted to the Department of Medicaid Services for approval subject to Kentucky Contract Section 4.4 “Approval of Department.”

WellCare Health Plans	**Procedure**
Manual Section:	Corporate Policy and Procedures, Pharmacy Area, Pharmacy
Procedure Name:	Pharmacy Lock-In Program Procedure
Procedure Number:	C20-RX-022-PR-001
Related Policies & Procedures:	C20-RX-022
Previous Policy and Procedure Number(s):	C20RX-022-PR-001
Effective Date: (Compliance Use Only)	08/29/05
Repealed Date: *(Compliance Use Only)*	N/A
Procedure History: (Compliance Use Only)	Reviewed, Revised and Approved: 7/29/2024 Reviewed, Revised and Approved: 08/31/21 Reviewed, Revised and Approved: 07/29/19 Reviewed, Revised and Approved: 05/05/20 Reviewed, Revised and Approved: 10/12/18 Reviewed, Revised and Approved: 10/08/19 Reviewed, Revised and Approved: 10/09/18 Reviewed, Revised and Approved: 08/19/19 Reviewed, Revised and Approved: 05/17/16
Department Policy Administrator (DPA):	Gersch, Jennifer
Company-Wide Procedure? (Y/N)	N
If no, Applicable to:	Medicaid: AZ, HI, KY
Current State Approval Date(s) (Compliance Use Only)	KY: 05/15/2018 HI: 07/26/19
Most Current Version and Electronic Approvals are located in C360	

Executive Summary:

This procedure supports policy C20-RX-022.

Procedure(s):

The Pharmacy Lock-In Program, (the "Program") has been established to restrict members whose pharmacy utilization patterns are documented as being excessive. The intent of the Program is to provide controls over which pharmacy the members can access and provide appropriate referrals to care management . The Program improves quality and safety of care, provides continuity of medical care, minimizes duplicate therapy or excessive drug quantities, and reduces unnecessary or inappropriate physician, pharmacy, and/or emergency room services. The members most likely to benefit from this service are those who see multiple physicians with

complicated drug regimens, utilize multiple pharmacies and those who have chronic pain issues.

State Specific Addendum(s):

- Addendum A: Hawaii Medicaid
- Addendum B: Kentucky Medicaid
- Addendum C: Arizona Medicaid

Attachments:

- Attachment A - ‘Ohana Member Letter
- Attachment B - ‘Ohana Provider Letter
- Attachment C - ‘Ohana Pharmacy Letter
- Attachment D- WellCare of KY Member Letter
- Attachment E- WellCare of KY Pharmacy Letter
- Attachment F- WellCare of KY Provider Letter

State Addendum B:	Kentucky Medicaid
Procedure Name:	Pharmacy Lock-In Program Procedure
Procedure Number:	C20-RX-022-PR-001
State Approval Date:	N/A

Procedure:

A Retrospective Pharmacy Drug Utilization Review (DUR) based on pharmacy claims data is performed on all members and is used to identify potential Lock-In enrollees. Additionally, referrals of members as candidates for Lock-In are accepted from physicians, pharmacists, and other health care providers. Once a referral is received, twelve months of pharmacy claims are reviewed to determine the appropriateness of pharmacy utilization.

Member is then enrolled in the single pharmacy and primary care physician (PCP) Lock-In program for twenty-four (24) months;.

The PBM system is used to lock members into the designated pharmacy and PCP.

New lock-in members that have been identified by the pharmacy lock-in team or were sent to us by the state, in which we are doing business, are sent to MedImpact once the above steps have been completed. This is done at a minimum of once a month. These lock-in members are sent to MedImpact to have lock-ins loaded into the MedImpact system.

If a change to the lock-in is required (i.e. new pharmacy or physician), the pharmacy lock-in team will log into the PBM system to make the change to the member's lock-in. In case of emergency, customer service can override the lock-in.

An Excel document of lock-in members is kept on the pharmacy SharePoint site and is updated monthly.

Candidates for enrollment are sent a letter of intent notification thirty (30) days prior to lock-in, which explains the restriction that will be applied and how to request an appeal if they wish to contest the decision for enrollment. The program assigns a lock-in pharmacy provider based on prescription claims history. The member is locked into the PCP on file in WellCare's Xcelys system. For the Commonwealth of Kentucky, the designated lock-in pharmacy is selected in accordance with Geographic Access Requirements of the Kentucky contract. For all programs, the designated lock-in program is geographically situated to give reasonable access to the member. All members assigned to Lock-in are offered case management and are contacted by a case manager prior to edits for pharmacy and prescriber are initiated.

Pharmacy Lock-In Criteria:

WellCare utilizes retrospective claims review to identify members that are candidates for the WellCare lock-in program.

The criteria for the retrospective review include members who:

- Excessively utilize provider services:
  - o Fill prescriptions at three (3) or more pharmacies; or
  - o Utilize three (3) or more physicians to obtain prescriptions;
  - o Use more than three (3) controlled substances in a thirty (30) day period; or
- Exhibit excessive use of emergency room services; had claims for 6 or more ER visits made at 3 or more distinct ERs in the past 12 months
- Receive duplicative drug therapy from different physicians

Claims for members are also reviewed to determine candidacy for lock-in upon referral from providers or pharmacies for members engaging in “doctor shopping” to receive prescriptions from multiple doctors. The WellCare Lock-in team reserves the right to utilize clinical judgement to guide determinations for overutilization and duplicative drug therapy.

Pharmacy Lock-In Status: While in Lock-In status, the member is restricted to one pharmacy and one PCP to obtain his/her prescriptions for a twenty- four (24) month period. Members enrolled in the Lock-in program are reviewed by the Pharmacy Lock-in team at least once during the twenty- four (24) month lock-in period. If after the annual review of the recipient’s drug-usage profile it is determined by the committee that restriction to the lock-in pharmacy is no longer appropriate, the restriction will be removed.

Pharmacy Change for Reasonable Cause: Members can change pharmacies for valid reasons such as an emergency supply while traveling, relocation, or if a drug item is out of stock at the assigned pharmacy. The pharmacy attempting to adjudicate the prescription must contact the pharmacy help desk on the members’ behalf to get a temporary override to adjudicate a script or to assist the member with being reassigned to a new pharmacy.
Without prior approval, pharmacies other than the assigned pharmacy are not paid if they fill prescriptions for the lock-in member. Electronic point-of-sale triggers alert pharmacies of any lock-in restrictions placed on an individual during real-time adjudication.

Case Management Referral: All members who are enrolled in the program are referred to WellCare’s Case Management department for additional monitoring, education and case management services. Members are contacted by a case manager prior to initiating pharmacy and prescriber edits.

Kentucky Contractual Requirements

Pursuant to Kentucky Managed Care Organization (MCO) Contract Section 33.10, “Lock-In Program”, WellCare shall develop a program to address and contain Enrollee over utilization of services, for pharmacy and nonemergent care provided in an emergency setting. The criteria for this program shall be submitted to the Department of Medicaid Services for approval subject to Kentucky Contract Section 4.4 “Approval of Department.”

Attachment D

WellCare of Kentucky Member Letter

RXDOPM – Kentucky Member RX Letter

<Logo[P1]>
<Return_Mail_Address[115]>

<Print Date[54]>

<First_Name[3]> <Middle_Initial[4]> <Last_Name[5]>
<Subscriber ID[22]>
<Address_Line_1[6]>
<Address_Line_2[7]>
<City[8]>, <State[9]> <Zip Code[10]><-Zip Extension[11]>

Dear <First_Name[3]> <Last_Name[5]>:

We hope this letter finds you in good health.

When you take different medicines, especially from different doctors, it can be confusing. It even could make you sick.

Your health is important to us. This is why we have placed you in WellCare's Lock-In Program. This program helps our members take their medicines the right way. It does not change any of your plan benefits.

Why did we do this? It is based on claims history data from <Claim_Start_Date[13]> through <Claim_End_Date[15]> that shows you are taking control substance medications from different providers or different pharmacies or have frequent visits to the Emergency Department.

Beginning on the Effective Start Date below, the Lock-In Pharmacy at the address below will be the only location where WellCare will pay for prescriptions. You must transfer all WellCare prescriptions from other pharmacies to the Lock-In Pharmacy below. Please speak to your pharmacist if you need help.

Also, you must get all of your control substance prescriptions from one prescriber. This may be your Primary Care Physician (PCP), unless your PCP has specifically referred you to another provider, who may also write you prescriptions. Your assigned control substance prescriber is:

<Physician_First_Name[49]> <Physician_Last_Name[43]>
<Physician _Address_1[23]>
<Physician _Address_2[25]>
<Phy_City[26]>, <Phy _State[29]> <Phy _Zip Code[30]>
<Physician _Number[31]>

Effective Start Date: <Lockin_Start_Date[48]> End Date: <Lockin_End_Date[28]>

Lock-In Pharmacy:

<Pharmacy_Name[32]>
<Pharmacy_Address_1[33]>
<Pharmacy_Address_2[34]>
<Rx_City[35]>, <Rx _State[36]> <Rx _Zip Code[37]>
<Pharmacy_Number[38]>

Why did we choose this Lock-In Pharmacy? It is because you picked up your medicine there within the past six months. Would you prefer a different pharmacy? We will be happy to help you. Just call us at <Toll_Free_No_Eng[60]>. We will need the name, address and phone number of your pharmacy of choice. After the Effective Date, all changes need a request and approval.

Also, as part of our Lock-In program, you have been assigned to case management. This is to help you deal with serious health problems that may be difficult to deal with on your own. Our Care Managers are medically trained. They can help you understand your illness and coordinate all your care to meet your needs, including:

- Setting up doctor's appointments
- Arranging for rides to appointments
- Setting up meals in the home (when medically necessary)
- Getting needed medical equipment set up in your home

Your team of Care Managers includes:

- Nurses
- Social workers
- Behavioral health care providers
- Staff to help identify community resources

A representative from Case Management will contact you shortly. We hope our Lock-In program and case management services give you the support you need to live a healthier life.

If you have questions about the WellCare Lock-In program, please contact our office.

By mail:

<Company[131]>
Pharmacy Department
<Cust_Serv_Address[114]>

By phone:

<Toll_Free_No_Eng[60]>

YOU HAVE THE RIGHT TO FILE AN APPEAL

If you do not agree with this decision, you or anyone you appoint can ask for an appeal. You may do that by phone or in writing. However, the request must be made within 30 days of the date of this notice. That review will be done by a person not related to the earlier decision. To do this, call Customer Service or send the information to:

<Appeals_Address[116]>

If you ask for an appeal by phone, you must also put it in writing and send it to us within 10 days of the day you called us. You have the right to give us any documents that relate to your appeal. You also have the right to look at your case file.

We must make a decision on a standard appeal within 30 days. However, you can ask for a faster appeal if you or your doctor thinks your health could be harmed by waiting. The faster appeal is done within 72 hours. We will consider your request and your health to decide if a fast appeal is needed. If not, your review will be done within 30 days.

It is not necessary, but you have the right to choose someone to act for you. That could include a lawyer. We must have your permission to disclose your health information to anyone. This may be done at all stages of the review process. The State can also provide a representative through its health insurance consumer ombudsman. If you wish to use that service, call **<Ombudsman_No[56]> (TTY/TDD <Ombudsman_TTY[57]>)**.

We can help you with your appeal request. Call **<Toll_Free_No_Eng[60]> (<TTY_Number[62]>).** We're here for you <Days of operation[112]> <Hours of operation[113]>.

You Have the Right to Request a State Fair Hearing

You have the right to request a State Fair Hearing if you do not agree with the decision of the appeal. You must ask for a hearing **in writing and clearly give the reason for the request**. Send your request for a hearing to:

Office of Commissioner
Department for Medicaid Services
Cabinet for Health and Family Services
275 East Main Street
6th Floor
Frankfort, KY 40621-0002

Your hearing request **must** be postmarked within **45** calendar days from the date of the Plan's Final Decision Letter.

You may be able to keep getting care during the hearing until a decision is made. You will need to ask for a continuation of benefits within 10 days of the mail date of this letter.

If the provider does not participate with Kentucky Medicaid or the service you received is not covered under Kentucky Medicaid and you were informed of the financial responsibility before the service was provided, you will be responsible for payment.

Other things to know:

- You do not have to pay for the Appeal or State Fair Hearing.
- You have the right to name someone you trust to file a State Fair Hearing for you. You must give the person your written O.K. to represent you.

If you have any questions, please call Customer Service at **<Toll_Free_No_Eng[60]>**

(<TTY_Number[62]>). We're here for you <Days of Operation[112]> <Hours of Operation[113]>.

Sincerely,

<Company[131]>

Attachment E

WellCare of Kentucky Pharmacy Letter

RXDOPX
Pharmacy Letter
Kentucky

<Logo[P1]>
<Return_Mail_Address[115]>

gggt<Print Date[54]>

<Pharmacy_Name[5]>
<Pharmacy_Address_Line1[6]>
<Pharmacy_Address_Line2[7]>
<Rx_City[8]>, <Rx_State[9]> <Rx_Zip Code[10]>
<Pharmacy_Number[38]>

Re: <First_Name[64]> <Middle_Initial[65]> <Last_Name[66]>
ID#: <Subscriber ID[22]> DOB: <DOB[50]>

Dear Pharmacy Provider:

In a continual effort to promote quality care and treatment for our members, <Company[131]> has implemented a quality improvement program to identify members who are using multiple providers, multiple pharmacies and multiple controlled substances in a 30-day period. The purpose of this program is to control duplicate and inappropriate drug therapy of controlled substances. A review of the above member's pharmacy claims history detected overutilization in at least one of these areas.

This letter is to inform you that this member has been assigned to the Pharmacy Lock-In Program. The purpose of this program is to monitor and manage a member's use of pharmacy services for a specified time frame.

The member will be assigned to your pharmacy for all prescription medication needs for 24 months, effective 30 days from the date of this letter. **The member's pharmacy benefits will stay the same.**

The member has been assigned to one prescriber for all controlled substances, <Physician_First_Name[49]> <Physician_Last_Name[43]> and must obtain all controlled substance prescriptions from this prescriber. The member can change pharmacies if an emergency supply is needed:

- While traveling
- If the member has moved
- If a drug is out of stock at the assigned pharmacy
- For other reasons that may be deemed appropriate

WellCare of Kentucky greatly appreciates your support in coordinating the health care of this member. Realizing there may be clinical circumstances for members to use multiple controlled substances from multiple providers, the member's Primary Care Physician has been notified.

If you need more information about the Pharmacy Lock-In Program, or if you are unable to help in the management of prescription services for this member, please contact our office.

By mail:

<Company[131]>
Pharmacy Department
<Cust_Serv_Address[114]>

By phone:

<Toll_Free_No_Eng[60]>

Thank you for joining in our mission to help our members live better, healthier lives.

Sincerely,

<Company[131]>
Pharmacy Department

Attachment F
WellCare of Kentucky Provider Letter

<Logo[P1]>
<Return_Mail_Address[115]>

RXDOPP
Provider Letter Kentucky

<Print Date[54]>

<Physician_First_Name[03]> <Physician_Last_Name[05]>
<Physician_Address_1[06]>
<Physician_Address_2[07]>
<Phy_City[08]>, <Phy_State[09]> <Phy_Zip Code[10]>

Re: <First_Name[64]> <Middle_Initial[65]> <Last_Name[66]>
ID#: <Subscriber ID[22]> DOB: <DOB[50]>

Dear Dr. <Physician_First_Name[03]> <Physician_Last_Name[05]>:

In a continual effort to promote quality care and treatment for our members, <Company[131]> has implemented a quality improvement program to identify members who are using multiple providers, multiple pharmacies and multiple controlled substances in a 30-day period. The purpose of this program is to control duplicate and inappropriate drug therapy of controlled substances. A review of <First_Name[64]> <Middle_Initial[65]> <Last_Name[66]>'s pharmacy claims history detected overutilization in at least one of those areas.

This letter is to inform you that your patient has been assigned to the Pharmacy Lock-In Program. The purpose of this program is to monitor and manage a member's use of pharmacy services for two years. **The member will only be allowed to fill controlled substance prescriptions written by you for the duration of the lock-in**.

The member will be assigned to the following pharmacy for all controlled substance prescriptions for 24 months, effective 30 days from the date of this letter:

<Pharmacy_Name[32]>
<Pharmacy_Address_1[33]>
<Pharmacy_Address_2[34]>
<Rx_City[35]>, <Rx_State[36]> <Rx_Zip Code[37]>
<Pharmacy_Number[38]>

Although the member's pharmacy is restricted, the member's **pharmacy benefits will stay the same**.

WellCare greatly appreciates your support in coordinating the health care of this member. Realizing there may be clinical circumstances for members to use multiple controlled substances from multiple providers, you may be aware of this utilization and consider it acceptable. If so, you may contact our office.

If you need any more information about the Pharmacy Lock-In Program, please contact our office.

By mail:
<Company[131]>
Pharmacy Department
<Cust_Serv_Address[114]>

By phone:
<Toll_Free_No_Eng[60]>

Thank you for joining in our mission to help our members live better, healthier lives.

Sincerely,

<Company[131]>