State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage Under the Affordable Care Act

Section 1314:

Communities of Care

December 2013

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage Under the Affordable Care Act

Rules and Regulations Section 1314:

Communities of Care

TABLE OF CONTENTS

Section Number	*Section Name*	*Page Number*
	1314: Communities of Care	
1314.01	Overview	1
1314.02	Scope and Purpose	1
1314.03	Definitions	1
1314.04	Target Population and Notice of Participation	2
1314.05	Health Profiles	2
1314.06	Restricted Provider Network (RPN)	2
1314.07	Member Outreach and Engagement	4
1314.08	Care Management / Peer Navigator	4
1314.09	Development and Implementation of Personal Rewards	4
1314.10	Completion of CoC Program Enrollment	5
1314.11	Severability	5

Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1314 of the Medicaid Code of Administrative Rules entitled, "Communities of Care"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et. seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

1314 Communities of Care

1314.01 Overview

The goal of the Medicaid program is to ensure that all eligible individuals and families have access to high quality, cost effective care that promotes health, safety and independence. Toward this end, the Medicaid agency has established a special service delivery system within both RIte Care and Rhody Health Partners (RHP) managed care plans called the Communities of Care (CoC). The goal of the CoC is to improve access and promote member involvement in care in an effort to decrease non-emergent and avoidable Emergency Department (ED) utilization and associated costs.

Note: Members of Connect Care Choice, eligible under MCAR sections 0374 and 0375, are also subject to CoC enrollment.

1314.02 Scope and Purpose

Eligible members of the Medicaid Affordable Care Coverage Groups, as specified in section 1301 of the Medicaid Code of Administrative Rules (MCAR), and non-MAGI coverage groups enrolled in RIte Care (section 1309) and RHP (0374) must participate in the CoC if directed to do so by the Medicaid agency. The purpose of this rule is to identify the target populations for the CoC within these service delivery systems, describe the central components of the CoC, and to define the respective roles and responsibilities of Medicaid enrollees and the State, as represented by the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency.

1314.03 Definitions

"Communities of Care (CoC)" means the special delivery system that provides more intensive care management within a limited network to Medicaid members enrolled in either RIte Care or Rhody Health Partners who have Emergency Department utilization rates at or above the threshold for participation set by the Medicaid agency.

"Enrollee" means a Medicaid member or beneficiary who is enrolled in a Medicaid managed care plan.

"Health Services Utilization Profile" means the health plans will continuously identify Communities of Care enrollees through several mechanisms: (1) utilization analysis of the health plans claims system, (2) identification from hospital ED reports, (3) provider referrals, and (4) other appropriate methods selected by the Contractor.

"Individualized Incentive Plans" means CoC Members will be eligible to receive incentives and rewards to promote personal responsibility, accountability and good health care practices.

"Managed Care Organization (MCO)" means a health plan system that integrates an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and place emphasizes preventive and primary care.

"Medicaid Affordable Care Coverage (MACC) Group" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

"Medicaid Code of Administrative Rules (MCAR)" means the compilation of rules governing the Rhode Island Medicaid program promulgated in accordance with the State's Administrative Procedures Act (R.I.G.L. §42-35).

"Medicaid member" means a person who has been determined to be an eligible Medicaid beneficiary.

"**Non-MAGI Coverage Group**" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

"Peer Navigator" means paraprofessionals with specialized training who are community resource specialists employed and supervised by peer advocacy organizations.

"Restricted Provider Network" means a limited network of health providers, selected by the CoC member, that must provide all of the member's primary care, narcotic prescription care, pharmacy and behavioral health care while participating in the CoC.

1314.04 Target Population and Notice of Participation

The target population for the CoC is Medicaid members who utilize the ED four (4) or more times during the most recent twelve (12) month period. RIte Care and RHP members must be notified of the requirement to participate in CoC in writing. The notice must include an overview of the CoC, a statement of plan and member responsibilities, all applicable appeal rights and duration of services. The EOHHS reserves the right to make exceptions to CoC participation when clinically appropriate.

1314.05 Health Profiles

The Medicaid agency is responsible for developing a Health Service Utilization Profile. The EOHHS or its contracted MCO will create a health services utilization profile for each CoC member based on the services used and determine whether the member is eligible for the Restricted Provider Network or the Select Provider Referral as specified below.

Health plans will complete a utilization profile for every member identified for enrollment in Communities of Care. The profile will be completed for all Communities of Care enrollees within fifteen (15) days of identification for enrollment. The primary purpose of this profile is to review the member's complete utilization/claims history and determine if there is a care management component in place via the health plan or in association with the member's primary care medical home and whether the member is a candidate for the restricted provider network (Lock-In).

1314.06 Restricted Provider Network (RPN)

CoC members who have certain patterns of utilization are enrolled in a restricted provider network in which they must select and use a specific set of health care providers. CoC members are locked-in to this network – that is, cannot choose other providers – for the duration of their participation in the CoC.

01. Utilization Patterns – Any Medicaid enrollee demonstrating one or more of the following utilization patterns/practices within a consecutive 180-day period will be enrolled in the RPN of CoC:

- ED visits with three (3) or more different Emergency Departments in a consecutive 180-day period;
- Utilization of four (4) or more different primary care providers (PCPs)s in a consecutive 180-day period;
- Utilization of four (4) or more different behavioral health providers in a consecutive 180-day period;
- Prescriptions at six (6) or more different pharmacies in a consecutive 180-day period;
- Received controlled substances from four (4) or more different providers in a consecutive 180-day period;
- A medical billing history during past 180 days that suggests a possible pattern of inappropriate use of medical resources (e.g., conflicting health care services, drugs, or supplies suggesting a pattern of risk); and
- Other relevant patterns that emerge during the utilization profile.

02. Assignment to Restricted Provider Network -- CoC members identified to enroll in the RPN (lock-in) must select the following providers:

- One PCP
- One pharmacy
- One narcotic prescriber and/or psychiatric medication prescriber (as appropriate based on health utilization profile and case review)
- One or more mental health and/or substance abuse providers, as appropriate.

03. Lock-in – Once the RPN providers have been selected, CoC members must obtain their care from the selected providers.

04. Exemptions -- A member may be exempt from assignment to the RNP when deemed clinically appropriate by the Medicaid agency or the recommendation of the Medical Director of a Medicaid MCO subsequent to further review of the member's health service utilization profile.

05. Member Rights – CoC members must be notified by the Medicaid agency of their right to appeal assignment to the restricted provider network CoC option.

1314.07 Member Outreach and Engagement

The Medicaid agency, or its contracted MCO, must conduct outreach to eligible CoC members to identify the causes for utilization of the ED for non-emergent conditions, and to discuss strategies for reducing reliance on ED utilization in the future. This includes providing information on how to improve connections with care providers, to avoid acute episodes, to improve management of chronic conditions. During outreach, the Medicaid agency, or its contracted MCO, must review the CoC program and the member's rights and responsibilities. This includes explanation of the RPN and SPN and associated appeal rights.

1314.08 Care Management / Peer Navigator

CoC enrollees must be assigned a care manager to assist them in developing an individualized care plan. CoC members may be referred to a peer navigator as well. The role of the peer navigator is to assist the CoC member in reducing barriers to care, to access medical and non-medical resources, and to guide the CoC member throughout the care coordination and treatment process.

The peer navigator will assist the member in reducing barriers to care, accessing medical and community resources and assist the member throughout the care coordination and treatment process. This includes but is not limited to:

(1) assistance with making appointments for health care services;

(2) canceling scheduled appointments if necessary;

(3) assisting members with transportation needs;

(4) following up with members and providers to assure that appointments are kept;

(5) rescheduling missed appointments;

(6) linking members to alternatives to ED use for non-emergency care, when needed;

(7) assisting members to access both formal and informal community-based support services such as child care, housing, employment, and social services;

(8) assisting clients to deal with non-medical emergencies and crises;

(9) assisting clients in meeting care plan goals, objectives and activities;

(10) providing emotional support to members, when needed; and

(11) serving as a role model and guiding the member to practice responsible health behavior.

1314.09 Development and Implementation of Personal Rewards

Individualized incentive plans will be developed for each CoC member, based on the member's care plan, which reward specific behaviors and achievements consistent with CoC goals. The incentive plans are developed by the member's care manager and/or peer navigator, in conjunction with the member. Members shall be able to select their incentives and rewards, based on a prescribed menu of options, to assure they are meaningful. Examples of possible incentives or rewards include gift cards, digital thermometers or recognition events.

An individualized incentive plan, consistent with the member's care plan, will be developed for each enrollee. The incentive plan will reward achievement of care plan goals, objectives and/or activities. Members will be able to select their incentives and rewards, based on a prescribed menu of options to assure Member meaningfulness to the reward program.

1314.10 Completion of CoC Program Enrollment

Completion of participation in CoC will occur under the following circumstances:

- The CoC member's care plan objectives are achieved.

- Medicaid eligibility is discontinued for any reason.

- At the discretion of the Medicaid agency, after a minimum of 12-months enrolled in the program.

The Medicaid agency or the contracted MCO must provide appropriate notice to the CoC member in each of the circumstances.

1314.11 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.