State: RHODE ISLAND

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Rhode Island enrolls Medicaid beneficiaries on a voluntary basis into managed care entity Primary Care Case Management (PCCM)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to allow certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
_X_ ii. PCCM
____ iii. Both

Background:

The Rhode Island Executive Office of Health and Human Services (EOHHS), (Rhode Island Medicaid) is submitting a change request to the Rhode Island State Plan Amendment, with an effective date of July 1, 2013 to enroll Medicaid-only adults with disabilities and elders, and Medicare-Medicaid eligibles (MMEs) into a managed care delivery system for all Medicaid-funded acute, primary, behavioral health and long-term services and supports benefits, entitled the Integrated Care Initiative (ICI). This request supports the Connect Care Choice Community Partners program.

Under the ICI, EOHHS intends to improve care for Medicaid-only and Medicare-Medicaid eligibles (MMEs) by achieving coordination and integration of Medicaid-funded acute care, primary care, and long-term care services for as many segments of the population of adults with disabilities and elders as is feasible. Currently, approximately fifteen (15) percent of Medicaid-only in this population are enrolled in Connect Care Choice for their acute,

primary and behavioral health care benefits. The state will build on this program and provide a enhanced Primary Care Case Management (PCCM) option, Connect Care Choice Community Partners (CCCCP). This program partners with a Coordinating Care Entity (CCE). The CCE will build a Community Health Team (CHT) to assist with the integration and coordination of the Medicaid-funded acute, primary and long-term care services for Medicaid-only and MME members. A monthly per member per month payment will be paid to the Coordinating Care Entity for the services outline in the contract. The CCCCP program target start date is November 1, 2013, pending approval from CMS.

Program Description:

The Connect Care Choice Community Partners (CCCCP) builds on the Primary Care Case Management (PCCM) Program, entitled Connect Care Choice (CCC), through the enhanced service coordination designed to be an additive to the CCC program. The coordination of long term services and supports for members with multiple chronic conditions and social issues will help the individual achieve the best health outcomes possible. The CCCCP is designed to leverage the existing service delivery present in the CCC and further it through the use of a Coordinating Care Entity which will build and implement a Community Health Team (CHT). The CCCCP program would be extended to Medicare and Medicaid individuals (only for Medicaid services) and Medicaid-only individuals who meet program enrollment criteria. This program will be operated under the direction of the Office of Long Term Services and Supports within the Rhode Island Medicaid Program.

Connect Care Choice (CCC)

The CCC program provides care management to Rhode Island Medical Assistance medically complex individuals. Currently, the CCC program has agreements with primary care practice sites, meeting standards of performance adopted from the chronic care model of "best practices", serving approximately 1,800 Medicaid-only adult beneficiaries across Rhode Island. The CCC model encompasses primary care/nurse case management teams and co-located behavioral health to provide quality focused, holistic and integrated care to beneficiaries. CCC program is designed to achieve and preserve access to primary, preventive, behavioral health and specialty care that allows the individual to remain well and independent in the community and decrease unnecessary acute episodes of care.

Connect Care Choice Community Partners (CCCCP)

The Connect Care Choice program evolution to the Connect Care Choice Community Partner is designed to address the needs for greater integration of primary care, acute care and long-term care services and for high touch, person-centered care management for both Medicaid only adults and for Medicare and Medicaid eligible (MME) adults in Rhode Island. A Coordinating Care Entity (CCE) contract will be sought to build a Community Health

State: RHODE ISLAND

Citation | Condition or Requirement

Team (CHT) that will focus on community based services, resources and supports and would oversee and manage the performance data, quality assurance and quality improvement activities. The CCE will have demonstrated expertise and the necessary tools to perform the care/ case management, care coordination, transition services, nursing facility inpatient quality care oversight for non-skilled care, social supports, housing, and transportation supports, and services integration functions in collaboration with the CCC practices. For Medicaid-only individuals, the CCCCP will be a direct expansion of the existing CCC program to include a sharper focus on long-term care services.

Delivery System:

The Connect Care Choice Community Partners (CCCCP) will contract with a Coordinated Care Entity (CCE). The CCE will provide program enrollment, member services, analytic risk profiling and assessments, establish and perform the Community Health Team (CHT) activities and will provide operational and quality data reports to the State. The assessment and risk profile are used to determine the level of need and are the basis for assigning the lead care manager. The additional care coordination/management services will be performed in collaboration with the care management responsibilities of the current Connect Care Choice nurses and practice sites and is not duplicative. Depending on the person's unique needs, the member will be assigned a lead care manager. As designed, the activities of the CCC practices and the CCE work in collaboration to integrate the medical clinical care management with the long term services and supports (LTSS) care management and coordination to ensure that person is able to remain living well in the most appropriate setting. Please see the attached Table 1

Lead Care Manager

All members receiving care management services have a designated Lead Care Manager according to the following requirements:

- The Member's principal care needs determine the background, training and experience of the Lead Care Manager.
- Members with complex and chronic medical conditions or who are at risk of hospitalization have a Care Manager that is a registered and licensed nurse that is currently serving as a Connect Care Choice Nurse Care Manager.
- Members receiving LTSS have a State Staff Care Manager that are either a registered and licensed nurse or a Social Worker working in the Office of Community Programs (OCP) or the Division of Elderly Affairs (DEA) Social Worker working with a contracted community based care management agency delivering Medicaid funded LTSS services.
- Members who need assistance with social supports and community linkages will

State: RHODE ISLAND

Citation	Condition or Requirement

be referred to the Community Health Team (CHT) Lead Care Manager.

- The CHT staff will meet the established State approved minimum qualifications and experience for Care Managers that include a registered and licensed nurse, licensed Social Worker or paraprofessional. The paraprofessional may conduct the assessment under the supervision and oversight of a licensed clinician.
- The Contractor shall establish policies and procedures for assigning individuals to a Lead Care Managers to best meet the needs and preferences of the member, the intensity of support required based on the intensity of their medical, behavioral health, and long-term needs and existing informal support system.

Lead Care Manager Coordinating Care Entity's Community Health Team:

A member of the Coordinating Care Entity's (CCE's) Community Health Team (CHT) will serve as the Lead Care Manager for members who have non-medical social services needs, require linkages to and coordination with community resources, or require a "peer mentoring" relationship. The responsibilities of the Lead Care Manager for these members include, but are not limited to:

- Participate in development of a Plan of Care
- Conduct in-person home visits and assessments
- Outreach to members
- Assist with making appointments for health care services in conjunction with the Connect Care Choice care manager
- Assist with transition follow up for post-acute care as needed
- Assist with transportation needs
- Assist members to access both formal and informal community-based support services such as child care, housing, employment, transportation and social services
- Assist members to deal with non-medical emergencies and crises; however, they will not serve as a "gatekeeper" for Medicaid services
- Assist members in meeting Plan of Care goals, objectives and activities
- Provide emotional support to members, when needed
- Coordinate the provision of care with providers and other care managers
- Enroll members in the RI Special Needs Emergency Registry, which keeps on file those members that have special needs if an emergency (i.e. natural disaster) should occur
- Serve as a role model in guiding the member to practice responsible health behavior
- Assist with housing needs, food stamps, utility services supports
- Assist with linkages to caregiver support resources

State: RHODE ISLAND

Citation	Condition or Requirement

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

X	i.	Fee for service;
	ii.	Capitation;
X	iii.	A case management fee;
	iv.	An incentive payment;
	v.	A supplemental payment, or
X	vi.	Other. (Please provide a description below).

In the CCCCP program, payments for Medicaid covered services will be made on a fee-for-service basis through the existing Medicaid Fee- For-Service program. Payment to the Connect Care Choice Primary Care Providers will continue to be made in accordance with the enhanced premium fee schedule and monthly per member per month case management fee. The Primary Care Providers are paid on a FFS basis consistent with the statewide fee schedule except for specific E and M codes that are paid at an enhanced fee schedule (80% of the Medicare fee schedule) detailed in their contract that also includes a case management fee for enrolled members in their practice. The Primary Care Providers are the only providers who receive a case management fee for coordination with other physicians and specialist.

The contract for the Coordinating Care Entity (CCE) will include a per member per month (PMPM) reimbursement. The payment structure is a monthly prospective payment for each premium rate category made to the CCE on behalf of each member enrolled for the required activities outlined in the CCE contract.

The projected PMPM costs are reimbursed by premium payment group for as follows:
Members with Severe and Persistent Mental Illness
Members with Developmental Disabilities
Members receiving long term services and supports in the community
Members receiving long term services and supports in a nursing home
Members residing in the community with no long term services and supports

The specific rates are outlined in Attachment F of the Coordinated Care Entity for the Integrated Care Initiative for Medicare and Medicaid Beneficiaries Contract that will be submitted to CMS Regional Office for review and approval.

Citation	Condition or Requirement

The specific Connect Care Choice Participation Standards and rates have been approved by the CMS Regional Office.

Provider Contract Standards:

- Adherence to contractual terms
- Clinical staff member must be in good standing with State and Federal regulatory authorities
- Services provided must be in accordance with treatment plan approved by licensed individual
- Service coordination interventions will be problem focused and solution oriented, well defined and clearly related to treatment goals and objectives, as well as tailored to the specific needs of the recipient
- Home and community care emergency back up plan coverage will be provided on a 24/7 basis per week for individuals transitioned to the community from an institutional setting if there is a disruption in the individual on-going support
- Member will be an integral part of care delivery team and involved in assessment, care planning, care delivery and evaluation process

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

_X_ i. Incentive payments to the PCCM will not exceed 5% of the total

FFS payments for those services provided or authorized by the PCCM for the period covered.

_X_ ii. Incentives will be based upon specific activities and targets.

_X_ iii. Incentives will be based upon a fixed period of time.

_X_ iv. Incentives will not be renewed automatically.

_X_ v. Incentives will be made available to both public and private

State: RHODE ISLAND

Citation	Condition or Requirement

PCCMs.

X vi. Incentives will not be conditioned on intergovernmental transfer agreements.

___ vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

EOHHS conducted an extensive outreach effort to describe the program initiative and to seek input from the various interested parties to guide in the development of the managed health care options for adults with disabilities living in the community. Over 28 community forums were held, with 255 consumers, providers, advocates, and representatives of health plans, state agencies, and CMS attending the forums. EOHHS will also utilize the bi-monthly Consumer Advisory Committee meetings to provide program implementation and continued operational updates and program outcomes to this group to insure ongoing public involvement.

The DHS project team also conducted presentations and feedback sessions with several groups of providers, including:

- The Primary Care Advisory Committee (PCPAC), representing both a mix of primary care disciplines and private and health center physicians. The PCPAC also serves as an advisory committee to the R.I. Department of Health on issues concerning primary care.
- The Rhode Island Medical Society
- Lifespan / Rhode Island Hospital Ambulatory clinics
- Medical Directors of the R.I. Community Health Centers
- Board of Directors of the R.I. Community Health Centers
- Medical Directors of the R.I. Community Mental Health Centers
- Administrators of the R.I. Community Mental Health Centers
- Medical Directors at MHRH

The Connect Care Choice Community Partners program is one of the managed care pathways on the Integrated Care Initiative. EOHHS produced a report for the RI General

State: RHODE ISLAND

Citation	Condition or Requirement

Assembly as well as a Demonstration Proposal to CMS for the Financial Alignment Demonstration. EOHHS held two Open Meetings on the reports in the spring of 2012 and provided Tribal Notice.

EOHHS had made and will continue to make significant efforts to involve and inform stakeholders in this delivery system redesign effort. EOHHS maintains an email list-serve of more than 500 stakeholders, and uses that email to inform stakeholders of public meetings, new documents on the website, and updates on the time line for implementation. Over the summer, EOHHS conducted an intensive stakeholder workgroup process.

From July 9, 2012 – August 10, 2012, EOHHS offered a series of workgroup meetings which met three times over this five week period. Each workgroup covered topics selected as imperative to the planning, development, implementation, and monitoring of the Integrated Care Initiative. Each workgroup meeting was co-facilitated by topic experts from the community as well as an EOHHS representative. The three topic areas were:

- Outreach and Information
  - This workgroup provided recommendations for a strategy to facilitate and build successful relationships with the member and provider community through increased awareness and engagement, recommended a process to disseminate communications to those stakeholders and keep them connected and informed in an ongoing manner.

- Services and Supports
  - This workgroup provided recommendations for defining the necessary requirements for creating a comprehensive provider network to address health care needs including but not limited to acute care, specialty, long term services and supports and behavioral health; assisted EOHHS to define appropriate requirements for a responsive care management program (i.e. care models), and recommended alternative benefits that may assist in keeping people healthy and residing in the community.

- Oversight, Evaluation, and Continuous Improvement
  - This workgroup provided recommendations for determining the appropriate quality performance measures for individuals enrolled in the program to monitor outcomes; and assisted in developing a process for oversight, evaluation, and continuous quality improvement.

Each workgroup was open to any stakeholder and community member. Recommendations from the workgroups advised EOHHS' development of procurement

State: RHODE ISLAND

Citation	Condition or Requirement

documents for the procurement of CCCCP and Rhody Health Options. Approximately 50 people participated in each workgroup. All materials from the workgroup, as well as summary recommendations documents, are available at http://www.ohhs.ri.gov.

EOHHS continued with stakeholder meetings in the fall, by hosting two open forums focused on the current long-term services and supports programs funded and managed by Medicaid. The purpose of these open forums was to inform consumers, providers, advocates and potential bidders, of the current service delivery system. Approximately 100 people attended each open forum.

In addition to client mailings and the enrollment hotline, EOHHS is conducting "train the trainer" sessions with community based organizations that provide direct services to members or provide informal supports to members. These organizations will assist EOHHS in informing members about these delivery system changes. EOHHS has begun and will continue to conduct open public meetings and targeted stakeholder meetings with providers, advocacy organizations, and other community groups to increase awareness of the program and inform consumers.

EOHHS again furnished Tribal Notice regarding the Integrated Care Initiative in November of 2012.

1932(a)(1)(A)

5. The state plan program will __X__ implement voluntary enrollment into managed care (PCCM) on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory) _____

   ii. county/counties (voluntary)_____

   iii. area/areas (mandatory)_____

   iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

State: RHODE ISLAND

Citation	Condition or Requirement
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. __X__ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A)	3. ____The state assures that all the applicable requirements of section 1932
42 CFR 438.50(c)(3)	(including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. __X__ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4)	5. __X__ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1903(m) 1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. ____ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 447.362 42 CFR 438.50(c)(6)	7. __X__ The state assures that all applicable requirements of 42 CFR 447.362 for 42 CFR payments under any nonrisk contracts will be met.
45 CFR 74.40	8. __X__ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a voluntary basis. Fee-for-service adults, 21 and older living in the community, not in an Institution, SSI; Working Adults with Disabilities; Breast and Cervical Cancer Treatment Program; Low Income; Medically Needy; Waiver Eligibles

State: RHODE ISLAND

Citation	Condition or Requirement

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. __X__ Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)* Enrollment in CCCCP is voluntary with the option to switch to another managed care delivery system or Medicaid Fee For Service. Enrollment will be for recipients eligible for full Medicare, with the exception of several categories (i.e. recipients in LTACs, ICF/MR, out-of- state residential hospitals, incarcerated, or in hospice/end of life care on the enrollment start date). Enrollment will be effective on a monthly basis.

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. __X__ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. Native Americans will be eligible to enroll if they choose to do so.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. ____Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

1932(a)(2)(A)(iii)
42 CFR 438.50(d)(3)(ii)

iv. ____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

1932(a)(2)(A)(v)
42 CFR 438.50(3)(iii)

v. ____Children under the age of 19 years who are in foster care or other out-of-the-home placement.

1932(a)(2)(A)(iv)
42 CFR 438.50(3)(iv)

vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

1932(a)(2)(A)(ii)
42 CFR 438.50(3)(v)

vii. ____Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

State: RHODE ISLAND

Citation	Condition or Requirement

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____ i. Program participation,
____ ii. Special health care needs, or
____ iii. Both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

____ i. Yes
____ ii. No

1932(a)(2)
CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt 42 from mandatory enrollment: *(Examples: eligibility database, self- identification)*

i. Children under 19 years of age who are eligible for SSI under title XVI;

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

iii. Children under 19 years of age who are in foster care or other out- of-home placement;

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

1932(a)(2)
42 CFR 438.50(d)

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

State: RHODE ISLAND

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients who are also eligible for Medicare. Utilize aid codes in eligibility system and self-identified beneficiaries ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. Self-identified beneficiaries may voluntarily enroll.
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis SSI; Working Adults with Disabilities; Breast and Cervical Cancer Treatment Program; Low Income; Medically Needy; Waiver Eligibles
	H. Enrollment process PCCM will enroll members on a voluntary basis.
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. .

Citation	Condition or Requirement

Describe how the state's default enrollment process will preserve:
The state's default enrollment process is outlined the Beneficiary Assignment Algorithm described in Section H. 3.v.

i. The existing provider-recipient relationship (as defined in H.1.i).

ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

iii. The equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)* Of the Medicare and Medicaid eligible (MME) members attributed to the participating Primary Care Practice sites, seventy –five percent (75%) will be offered enrollment in the CCCCP and twenty-five percent (25%) will be offered the MCO. The 75/25 auto-assignment will be random in nature. The MME members will be offered the option to switch delivery systems or remain in Medicaid fee for service.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will____/will not __X__ use a lock-in for managed care managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be_a minimum of sixty (60) days_____.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Only beneficiaries with claims experience with a participating Primary Care Provider will be auto assigned on an "OPT OUT" basis to this provider These eligible beneficiaries will be notified by state generated correspondence that the program is available to them and that their primary care provider is a participating provider. The enrollment and disenrollment process is explained in this correspondence. The enrollment process uses an "OPT OUT" strategy,

State: RHODE ISLAND

Citation	Condition or Requirement

or if no contact is made by r the member in 60 days, the member will be enrolled in the PCCM.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

State generated correspondence at the time of enrollment.

Medicare recipients will be allowed to disenroll on a monthly basis.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Only those beneficiaries with claims experience with a qualified Primary Care Provider will be auto assigned on a "OPT OUT" basis.

Beneficiary Assignment Algorithm

Rhode Island adopted the Beneficiary Assignment Algorithm currently used under the CMS Multi-Payer Advanced Primary Care Practice Demonstration.

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all beneficiaries who meet the following criteria as of the last day in the look back period:
   - Reside in RI;
   - Have both Medicare Parts A & B;
   - Are covered under the traditional Medicare Fee-For-Service Program and are not enrolled in a Medicare Advantage or other Medicare health plan; and
   - Medicare is the primary payer;

3. Select all claims for beneficiaries identified in step 2 with the following qualifying CPT Codes in the look back period (most recent 24 months) where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, nurse practitioner, or physician assistant or where the provider is an FQHC.

State: RHODE ISLAND

Citation	Condition or Requirement

4. Assign a beneficiary to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.

5. If a beneficiary has an equal number of qualifying visits to more than one practice, assign the beneficiary to the one with the most recent visit.
6. Of the Medicare and Medicaid eligible (MME) members attributed to the participating Primary Care Practice sites, seventy –five percent (75%) will be offered enrollment in the CCCCP and twenty-five percent (25%) will be offered the MCO. The 75/25 auto-assignment will be random in nature
7. If there is no claims history for the Medicare and Medicaid eligible (MME) individual, the MME will be auto assigned to the Health Plan model.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Track through monthly reports.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. __X__ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _X__ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ___ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

__X__ This provision is not applicable to this 1932 State Plan Amendment.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and

State: RHODE ISLAND

Citation	Condition or Requirement

the recipient has a choice of at least two primary care providers within the entity. (California only.)

X This provision is not applicable to this 1932 State Plan Amendment.

5. X The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___/will not _X_ use lock-in for managed care. EOHHS is aware that beneficiaries may disenroll at any time.

2. The lock-in will apply for ____ months (up to 12 months).

3. Place a check mark to affirm state compliance.
X The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

Beneficiary does not receive primary care services from an enrolled provider and does not wish to do so.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)

L. List all services that are excluded for each model (MCO & PCCM)

Beneficiaries receive the Medicaid State Plan Services under the PCCM program.

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

State: RHODE ISLAND

Citation	Condition or Requirement

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not __X__ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. __X__ The selective contracting provision in not applicable to this state plan.