



RHODE ISLAND EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

Notice of Public Hearing and Public Review of Rules

The Secretary of the Executive Office of Health & Human Services (EOHHS) has under consideration a series of proposed new sections (as well as amendments to existing sections) of the Medicaid Code of Administrative Rules (MCAR) (“Regulations”) related to the expansion of the Medicaid Program under the provisions of health care reform statutes. (A summary of the rule changes appears below).

Under the authority granted in the federal Patient Protection and Affordable Care Act of 2010 (ACA) and applicable State law, including Executive Order 11-09, Rhode Island created its own health insurance marketplace and on-line eligibility system, previously referred to as a “health benefit exchange”, and elected to expand Medicaid eligibility to the new ACA coverage group of adults, without dependent children, who have income up to 133% of the Federal Poverty Level (FPL). On October 1, 2013 Rhode Islanders interested in obtaining health coverage under this new expansion group began applying through the health insurance marketplace (HealthSourceRI), the Department of Human Services (DHS) field offices or website, and/or the Executive Office of Health and Human Services website (EOHHS). Applicants deemed to be eligible began enrolling in one of two Medicaid health plans during the period from October 1, 2013 to December 31, 2013. Actual coverage begins on January 1, 2014. There will be no changes in Medicaid coverage until January 1, 2014.

The proposed rules seek to accomplish the following:

01. To describe the new income standard that will be used to determine access to coverage for the ACA expansion group beginning on January 1, 2014;
02. To amend existing Medicaid rules to provide for persons participating in Medicaid prior to January 1, 2014;
03. To identify the principal roles and responsibilities of the Medicaid agency and the State with respect to persons seeking eligibility for the new ACA expansion coverage group; and
04. To inform Rhode Islanders of their rights and responsibilities when seeking Medicaid eligibility as a member of the new ACA or existing coverage groups during this same period.

These regulations are being promulgated pursuant to the authority contained in Rhode Island General Laws Chapter 40-8 (Medical Assistance) as amended, 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; Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et. seq.*; Chapter 42-35 of the Rhode Island General Laws, as amended; and Chapter 42-7.2 of the Rhode Island General Laws, as amended.

In the development of these proposed Regulations, consideration was given to the following: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small businesses in Rhode Island. No alternative approach, duplication or overlap, or impact upon small businesses were identified based upon available information.

Notice is hereby given in accordance with the provisions of Chapter 42-35 of the Rhode Island General Laws, as amended, that the Secretary will hold two Public Hearings on the above mentioned matter on **TUESDAY, 3 DECEMBER 2013** at which time and place all persons interested therein will be heard.

Hearings will be convened as follows:

Tuesday, December 3, 2013 2:00 p.m.	Tuesday, December 3, 2013 6:00 p.m.
Arnold Conference Center 111 Howard Avenue Regan Building Pastore Complex Cranston RI 02920	DaVinci Center 470 Charles Street Providence, RI 02904

For the sake of accuracy, it is requested that statements to be made relative to any aspect of the Regulations, including alternative approaches or overlap, be submitted in writing at the time of the hearing or mailed prior to the hearing date to: Steven M. Costantino, Secretary, Rhode Island Executive Office of Health & Human Services, Louis Pasteur Building, 57 Howard Avenue, Cranston, Rhode Island, 02920 or via email to the attention of: eshelov@ohhs.ri.gov.

Interested persons may inspect said Regulations and other related materials on the Rhode Island Secretary of State's website: www.sec.state.ri.us/rules, on the Executive Office of Health & Human Services' website: www.eohhs.ri.gov or at the Executive Office of Health & Human Services, 57 Howard Avenue, Cranston, Rhode Island, 02920 between the hours of 9:00 a.m. and 3:00 p.m., Monday through Friday; by calling (401) 462-1575 {via RI Relay 711} or by emailing Eshelov@ohhs.ri.gov.

The Rhode Island Executive Office of Health & Human Services in the Louis Pasteur Building is accessible to persons with disabilities. If communication assistance (readers /interpreters /captioners) is needed, or any other accommodation to ensure equal participation, please notify the Executive Office at (401) 462-6266 (hearing/speech impaired, dial 711) at least three (3) business days prior to the Public Hearing so arrangements can be made to provide such assistance at no cost to the person requesting.



Steven M. Costantino, Secretary
Signed this 25th day of October 2013

Significant ACA-Related Changes in the Medicaid Program

The following provides a summary of the major changes in the Medicaid program authorized or mandated by the ACA and the applicable rules in this chapter:

- Consolidation and simplification of Medicaid coverage groups subject to MAGI-based eligibility determinations – MCAR section 1301.
- Elimination of Medicaid eligibility for parents/caretakers with income from 133% to 175% of the FPL – MCAR 1301.
- Expansion of Medicaid eligibility to adults, ages 19 to 64, without dependent children and establishment of a new Medicaid affordable care coverage group – MCAR section 1301.
- Streamlined application process through the automated affordable care eligibility system – MCAR 1303.
- Standardization of Medicaid eligibility requirements for MACC coverage groups – MCAR Section 1305.
- Establishment of passive renewal process for making determinations of continuing eligibility – MCAR section 1306.

- Implementation of the MAGI-based income standard – MCAR section 1307.
- Automated verification of eligibility requirements through federal and State data sources – MCAR section 1308.
- Elimination of premiums in the RItE Care managed care delivery system and redefinition of RItE Care coverage groups – MCAR section 1309.
- Enrollment of the MACC coverage group for adults without dependent children in a Rhody Health Partners managed care plans with a modified benefit package – MCAR section 1310.
- Modifications of the managed care enrollment system to complement changes in the application and eligibility determination processes – MCAR section 1311.
- Changes in the RItE Share premium assistance program to complement ACA initiatives, remove premiums, and add a buy-in requirement – MCAR section 1312.
- Extension of the Communities of Care requirement to MACC expansion group – MCAR section 1314.
- Implementation of a limited subsidy program for parents/caretakers with income from 133% to 175% of the FPL who are no longer eligible for Medicaid affordable care coverage – MCAR section 1315.

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

October 2013 (Proposed)

**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

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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 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. This Group includes Medicaid for persons who are aged, blind or with disabilities and 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 Payment 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

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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.