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 mandatory 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

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;
_X_ iv. an incentive payment;
____ v. a supplemental payment, or
_X vi. other. (Please provide a description below).

A network of co-located, Primary Care Providers and Behavioral Health Therapists will be developed in order to provide an integrated, holistic approach to the treatment of Connect Care Choice members determined to have chronic medical conditions and /or a non SPMI behavioral health condition. The program will be a collaborative, co-located Medical and Behavioral Health model. The co-located Behavioral Health Providers must be enrolled as Medicaid providers, and must also meet the participation standards for the Integrated Medical and Behavioral Health Program (described below). The Behavioral Health providers will be paid on a specific Level One Pricing FFS fee schedule basis (outlined in their participation

Citation	Condition or Requirement

standards agreement) for specific evaluation and treatment codes. This does not include a 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.

General Outpatient Services specific to Integrated Medical and BH are the managed services, paid on a FFS basis and detailed in the corresponding State Plan coverage pages and will include the following:

- Diagnostic Evaluation
- Psychological Testing
- Individual therapy
- Family Therapy
- Medication Management
- Behavioral Health Services for Medical Diagnosis

Requirements:

- Referral by Connect Care Choice (CCC) Primary Care Provider
- Must be co-located and integrated with current CCC Practice
- Office based counseling and therapy
- Collaboration with plan of care between primary care provider and therapist and Nurse Case Manager when appropriate
- Oversight and monitoring by Office of Long Term Services and Supports (OLTSS)

Benefits:

- 12 visits annually upon initial referral based on medical necessity and equity with the MCO program
- Prior authorization by OHHS/ Medicaid /Office of Institutional and Community Services and Supports (OLTSS)for additional visits
- Psychiatrist visits for medication management consultation

Provider Network: (co-located with primary care practice- will be enrolled as Connect Care Choice Providers)

- Psychologist
- Master's Level Social Worker (LICSW)
- Clinical Psychiatric Registered Nurse Specialist
- Psychiatrist

Provider Participation Standards:

Citation	Condition or Requirement

- Current License by Department of Health
- 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
- Treatment 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
- Coverage will be provided on a 24/7 basis per week and will include back up plan for instances where the clinician is not available
- Utilize innovative scheduling systems to minimize delays in getting appointments and standard office hours

Provider Role and Responsibilities:

- Providers will coordinate service planning and delivery of care with the Connect Care choice member's primary care provider (PCP)
- Maintain effective coordination and oversight by psychiatrists to ensure proper provision of prescription medications and medical management monitoring
- Member will be an integral part of care delivery team and involved in assessment, care planning, care delivery and evaluation process
- Provider will coordinate delivery of care with other specialist to promote self-management of chronic and complex conditions

Provider Enrollment:
To be enrolled as FFS Medicaid providers co-located in a Connect Care Choice Primary Care Practice

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 (which covers care coordination with other providers and care planning best practices for chronic medical conditions) 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.

Citation	Condition or Requirement
	__X_iv. Incentives will not be renewed automatically. __X__v. Incentives will be made available to both public and private 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.)*

DHS 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. DHS 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

1932(a)(1)(A) 5. The state plan program will_X__ implement mandatory

Citation	Condition or Requirement
	enrollment into managed care with choice of two entities, 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.
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) 42 CFR 438.50(c)(3)	3. __X__The state assures that all the applicable requirements of section 1932 (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) for 42 CFR 447.362 42 CFR 438.50(c)(6)	7. _X___The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.

Citation	Condition or Requirement
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 mandatory basis. Enrollment includes 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
	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. _______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.)*
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) CMS-PM-XX-X	vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

Citation	Condition or Requirement
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.

E. Identification of Mandatory Exempt Groups

Citation	Condition or Requirement
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) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* This section is inapplicable as children are not a covered population under this program. 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)*

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 Eligible's
	H. Enrollment process. PCCM will enroll members on a mandatory basis, with option to switch to MCO model, who already receive their primary care in the enrolled provider practice, have a claims experience with this participating provider, and have identified this provider as their primary care provider. PCCM members will be notified by mail that they have been enrolled into the Connect Care Choice Program at one of the 17 statewide primary care practice sites where they are currently receiving their primary care. The notice includes options to switch to the health plan model if they choose. New enrollees who choose the PCCM Model but do not currently have a primary care provider will be assisted in choosing one of the current CCC practice sites to receive their primary care.
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

Citation	Condition or Requirement
	ii. records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.
	iii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4)	2. State process for enrollment by default.
42 CFR 438.50	The PCCM model does have a default enrollment process as describes below and on subsequent pages.

Describe how the state's default enrollment process will preserve:

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 to a PCCM practice site if it is not the current or selected Primary Care site of the member)*

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__X__/will not____ use a lock-in for managed care MCO and PCCM

ii. The time frame for recipients to choose a health plan before being auto-assigned will be six weeks.

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 the MCO model) 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. Enrollment and disenrollment process is explained in this correspondence. PCCM members will be encouraged but not be required to receive BH services from the Integrated BH providers.

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.)*

Citation	Condition or Requirement

State generated correspondence at time of enrollment.

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 participating Primary Care Provider will be auto assigned on a "OPT OUT" basis.

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

Citation	Condition or Requirement
	_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. DHS 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) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM)
1932 (a)(1)(A)(ii)	M. Selective contracting under a 1932 state plan option
	To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

Citation	Condition or Requirement

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.)*

   Provider practices must meet the 1932(a) and the 1905(t) PCCM requirements, including the Department of Health state licensing requirements for primary care including all health care services customarily provided in accordance with State licensure and certification laws and regulations and all laboratory services provided by or through, a general practitioner, family medicine physician, internal medicine and the participation standards set by DHS to be enrolled as a participating provider.

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