State Profile

Summary of Care Coordination Contract Provisions for Rhode Island Medicaid Managed Integrated Adult Care Services in the Rhody Health Options Program

This summary was prepared for a study of care coordination in managed long-term services and supports programs, conducted by Truven Health Analytics for the AARP Public Policy Institute.[1] Contracts from the following states were included in the study: AZ, CA, DE, FL, HI, IL, KS, MA, MN, NJ, NM, NY, OH, RI, TN, TX, VA, and WI. The full report and contract summaries from the 18 states are available at www.aarp.org/carecoordination. The full report includes a compilation of findings across the states.

Rhode Island Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	Subset	All members who receive long-term services and supports in any setting must be offered care coordination. In addition, contractors are required to conduct telephonic health screening of all members and provide a comprehensive assessment and care coordination to others who are at risk and may benefit from it.
2) Can eligible members opt out of care coordination?	Yes	Contractor is required to document eligible members who decline care coordination and the reasons for declining.
3) Can members choose or change care coordinators?	Not addressed in contract	
Care Coordinator Qualifications		
4) Are care coordinators required to have college or nursing degrees?	Yes	For any member using long-term services and supports, the care coordinator must be licensed by the State to provide clinical services. This may be an RN for persons whose needs are primarily medical or a social worker or counselor for persons whose needs are primarily long-term services and supports.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Qualifications (continued)		
5) Are care coordinators required to have experience in long-term services and supports or disability?	No	Experience in long-term services and supports or disability is not specified.
6) Are care coordinators required to receive training?	Not addressed in contract	
Cultural Competency of Care Coordination		
7) Are care coordinators required to speak languages other than English when the other language is used by members?	No	Care coordinators are not required to speak a second language.
8) Are translation/interpretation services required when a care coordinator does not speak a member's language?	Yes	In general, the contractor is responsible for providing interpreters for members who need them. If 50 or more members need a particular language, the contractor is responsible for providing all written materials in that language.
Care Coordinator Assignments, Contact Requirements, and Role		
9) Are care coordinators with certain specialties (e.g., nursing, social work, behavioral health) assigned based on the needs of members?	Yes	Contract specifies that care coordinators must be assigned according to the needs of the members.
10) Is in-person contact required and at what frequency?	Yes	Quarterly home visits are required and one of the visits each year must be unannounced. Members in the RIte @ Home program must receive monthly home visits. (RIte @ Home places people in the homes of individuals who provide both care and a place to live, similar to an adult foster care model.)
11) Is telephonic or other remote contact required?	Yes	For all members receiving care coordination, the minimum contact is monthly, by phone.
12) Must initial contact with a new member be made within a specified time period?	Yes	New members receiving community-based long-term services and supports must receive an in-person visit within 15 days, and new members receiving institutional long-term services and supports must receive an in-person visit within 30 days, for purposes of receiving comprehensive assessments. All other new members must receive a telephonic initial health-risk screen within 45 days.
13) Is an assessment required at initial enrollment?	Yes	Members receiving long-term services and supports at enrollment must receive a comprehensive, in-person assessment. Other members must receive a telephonic health-risk screening and, as needed based on the screening, must receive a comprehensive assessment.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
14) Is reassessment required and at what frequency?	Yes	In-person reassessments must be performed as follows: • Receiving community-based long-term services and supports: every 90 days • Receiving institutional long-term services and supports: every 180 days • On request of member/caregiver: within 15 days • Upon hospital discharge: within 5 days In addition, reassessments must be performed more frequently as indicated by members' needs.
15) Does the care coordinator authorize long-term services and supports?	Other	The contract encourages decision making at the care coordinator level, but does not require it.
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Other	Contractor is responsible for the function. After the first 12 months of the program, the contractor may subcontract with the fiscal intermediary for care coordination for members who self-direct.
17) Does the care coordinator play a role when members use a transition program such as Money Follows the Person to move out of institutional settings?	Yes	Contractor must assign a person to be the transition coordinator to be the lead on all required care coordination during and after the transition.
18) Does the member have a single point of contact who coordinates across specialized coordinators when needed (e.g., coordinates across long-term services and supports, behavioral, medical specialists)?	Yes	Contractor must designate a lead care manager who is the point of contact for any member receiving care management.
Care Coordination Role with Family Caregivers		
19) Are family caregivers asked directly about (a) their own health and well-being; (b) level of stress and feelings of being overwhelmed; (c) need for training in assisting the member; and (d) any additional services or supports needed to better carry out their roles?	Other	Family caregivers must be included in the service planning process when requested by the member or legal representative. There is no requirement for assessing the family caregiver's needs.
20) Does the plan of care address needs of the family caregiver raised during the assessment process?	Other	Family caregiver's needs may be addressed if services are available. For example, respite is a covered service and may be provided if identified as a need.
21) Are family caregivers given care coordinator contact information?	Yes	If the member has consented to having the family caregiver participate in the planning process, the caregiver receives the contact information.
Care Coordination Information Tools		
22) Does the care coordinator have access to centralized member records?	Yes	Contractor is required to have integrated electronic information systems that provide all essential data to care coordinators. Contractor is encouraged to participate in the State's Health Information Exchange program.

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Element	Contract Requirement	Summary and Notes
Care Coordination Information Tools (continued)		
23) Does the care coordinator have access to an electronic care coordination program?	Not addressed in contract	
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	Other	Specific ratios are not set by the State, but the contractor must develop ratios for different levels of care and submit them to the State for approval.
25) Does state program monitoring include a specific focus on care coordination?	Yes	Contractor must submit measures quarterly, including several care coordination measures. On request, a sample of records must be provided to the State for validation.
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	Contractor is required to measure the effectiveness of the care management process by analyzing member outcomes.
27) Care coordination entity	Partners permitted	Contractor is responsible for care coordination but may provide it directly or through subcontractors. In either case, the care coordinators must be located within the State, and the contractor must describe the structure of its care coordination in a plan submitted to the State for approval.

Contract Reviewed: Contract between State of Rhode Island and Providence Plantations Executive Office of Health and Human Services and Neighborhood Health Plan of Rhode Island for Medicaid Managed Integrated Adult Care Services in the Rhody Health Options Program *(NHPRI RHO 14/16-001) (November 1, 2013).*

1 Saucier, P. and B. Burwell. 2015. *Care Coordination in Managed Long-Term Services and Supports*. AARP Public Policy Institute.

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601 E Street, NW
Washington DC 20049

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