CommunityCARE 2.0 Basics for Non-Primary Care Physicians

The CommunityCARE 2.0 program is a comprehensive health care system based on a primary care case management (PCCM) model. CommunityCARE 2.0 links Medicaid recipients with a primary care provider (PCP) who serves as the medical home managing all facets of the recipient's health care.

Recipient Participation Requirements

The following groups of Medicaid recipients are **mandated** to participate in the CommunityCARE 2.0 Program:

- Temporary Assistance for Needy Families (TANF) and TANF-related recipients,
- Supplemental Security Income (SSI) and SSI-related, non-Medicare, recipients who are age 19 up to age 65, and
- Children's Health Insurance Program (CHIP) recipients.

The following groups of Medicaid recipients may **voluntarily** participate in the CommunityCARE 2.0 Program:

- Recipients who are under age 19 and are in foster care, other out-of-home placement or receiving adoption assistance,
- Recipients who are under age 19 and are eligible for SSI under Title XVI or an SSI-related group,
- Recipients who are under age 19 and are eligible through a Home and Community-Based Services Waiver, or
- Recipients 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.

The following groups of recipients are **excluded** from participation in the CommunityCARE 2.0 Program:

- Recipients who are residents of:

- Nursing facilities,
- Intermediate care facilities for persons with developmental disabilities, and
- Psychiatric facilities

- Recipients who are age 65 or older,
- Dual eligible recipients (Medicare Part A or Part B coverage or both),
- Recipients who are refugees,
- Recipients who have other primary health insurance covering physician benefits, including health management organizations (HMOs)
- Medicaid hospice enrollees,
- Recipients with less than three months eligibility or retroactive only eligibility,
- Recipients who are eligible through pregnant woman eligibility categories,
- Recipients who are eligible through CHIP Phase IV unborn option,
- Recipients in the Program for All Inclusive Care for the Elderly (PACE),
- Recipients who are under age 19 **and** eligible through the CHIP Affordable Plan,
- Recipients who are eligible through the TAKE CHARGE Family Planning Waiver,
- Recipients who are in the Medicaid physician/pharmacy lock-in program (pharmacy only lock-in recipients are not exempt from participation), or
- Native Americans who are members of federally recognized tribes

Requests for enrollment exemptions are considered on a case-by-case basis for certain medically high risk recipients warranting the direct care and supervision of a non-primary care specialist.

If a CommunityCARE 2.0 recipient's Medicaid type changes to one that is exempt from CommunityCARE 2.0 program, the PCP linkage will end either at the end of the month that the

recipient's Medicaid file is updated with the new information or at the end of the second month following the change, depending on when the file is updated.

How to Identify CommunityCARE 2.0 Recipients

CommunityCARE 2.0 recipients may be identified through any of the Medicaid eligibility verification systems:

- Electronic Medicaid Eligibility Verification System (eMEVS)
- Medicaid Eligibility Verification System (MEVS)
- Recipient Eligibility Verification System (REVS)

NOTE: See Appendix A for information on how to access eMEVS and REVS.

The PCP's name and telephone number will be listed in the verification systems if the recipient is linked to a CommunityCARE 2.0 PCP. If there is no CommunityCARE 2.0 PCP information given, then the recipient is **NOT linked** to a PCP and may receive services without a referral/authorization.

NOTE: It is the Medicaid **provider's responsibility** to verify recipient eligibility and CommunityCARE 2.0 enrollment status through one of the above verification systems **BEFORE providing service.**

Primary Care Provider

As part of the care coordination responsibilities, PCPs are obligated to ensure medically necessary healthcare service referral authorizations are furnished promptly and without compromise for all services the PCP cannot/does not provide. The PCP shall not unreasonably withhold or deny valid requests for referrals/authorizations made in accordance with CommunityCARE 2.0 policy, and the PCP shall not require the requesting provider complete the referral authorization form. PCPs should issue appropriately requested referrals/authorizations as quickly as possible, taking into consideration the urgency of the recipient's medical needs, not to exceed a period of 10 days. This time frame was designed to provide guidance for responding to requests for post-authorizations. However, PCPs should respond to requests sooner than 10 days, if possible, and should not deliberately hold referrals/authorizations until the 10th day.

The PCP referral/authorization requirement does not replace other Medicaid policies in existence. For example, if the service requires prior authorization, the provider must still obtain prior authorization **in addition to** obtaining the referrals/authorizations from the PCP.

Services Exempt from Referrals

The following Medicaid covered services do not require authorization referrals from the CommunityCARE 2.0 PCP:

- Chiropractic service resulting from a KIDMED referral/authorization for children under the age of 21
- Dental services for children under the age of 21
- Dental services for pregnant women ages 21-59
- Dentures for adults
- The three higher level emergency room visits and associated physician services

  (**NOTE**: The two lower level emergency room visits and associated physician services do not require prior authorization, but do require POST authorization as specified in the CommunityCARE Handbook, "Emergency Services" section. See Appendix A for information on accessing the CommunityCARE Handbook)
- Inpatient care that has been pre-certified: hospital, physician, and ancillary services billed with inpatient place of service
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – rehabilitative type health services such as occupational, physical and speech/language therapy delivered to EPSDT recipients through schools or early intervention centers or the EarlySteps program
- Family planning services
- Prenatal/obstetrical services, including neonatalogy inpatient services
- Services provided through the Home and Community-Based Waiver programs
- Targeted case management
- Mental health services
- Ophthalmologist and optometrist services

- Pharmacy
- Inpatient psychiatric services (distinct part and freestanding psychiatric hospital)
- Transportation services
- Hemodialysis
- Hospice services
- Specific outpatient laboratory/radiology services
- Immunization for children under age 21 thru the Office of Public Health and their affiliates
- Services provided through the Office of Public Health Women, Infants and Children (WIC) and Children's Special Health Services programs
- Services provided to recipients age 10 and older by school-based health centers
- Services provided by urgent care facilities and retail convenience clinics.
    - These providers furnish walk-in, non-routine care as an alternative to emergency department care when access to primary care services is not readily available to meet the health needs of the recipient.
    - Urgent care facilities and retail convenience clinics must provide medical record notes of the visit to the recipient's PCP within 48 hours of the visit.
- Services provided by federally qualified health centers (FQHCs).
    - These providers furnish walk-in, non-routine care as an alternative to emergency department care when access to primary care services is not readily available to meet the health needs of the recipient.
    - FQHCs must provide medical record notes of the visit to the recipient's PCP within 48 hours of the visit.

Important CommunityCARE 2.0 Referral/Authorization Information

Any provider other than the recipient's PCP must obtain a referral from the recipient's PCP, **prior to rendering non-exempt, non-emergent (routine) services**, in order to receive payment from Medicaid. Providers who fail to obtain the appropriate referral/authorization from the

recipient's CommunityCARE 2.0 PCP prior to the service being provided risk non-payment by Medicaid. **Louisiana Medicaid and the fiscal intermediary will not assist providers with obtaining referrals/authorizations for care not requested in accordance with CommunityCARE 2.0 policy.**

PCPs are not required to respond to requests for referrals/authorizations for non-emergent/routine care not made in accordance with CommunityCARE policy: i.e. requests made after the service has been rendered.

When ancillary services such as durable medical equipment (DME) or home health are ordered by a provider other than the PCP, the ordering provider is responsible for obtaining the CommunityCARE 2.0 referral/authorization. For example, **when a recipient is being discharged from the hospital, it is the responsibility of the discharging physician/hospital discharge planner to coordinate with the recipient's PCP to obtain the appropriate referral/authorization. The hospital physician/discharge planner, not the ancillary provider, has all the necessary documentation needed by the PCP.** The ancillary provider should use eMEVS or MEVS to confirm that the referral/authorization they received is from the PCP and the recipient was linked to that PCP on the date of service. The ancillary provider cannot receive reimbursement from Medicaid without the appropriate PCP referral/authorization.

Depending on the medical needs of the recipient as determined by the PCP, referrals/authorizations for specialty care should be written to cover a specific condition and/or a specific number of visits and/or a specific period of time not to exceed six months. There are exceptions to the six-month limit for specific situations, as set forth in the CommunityCARE Handbook. When the PCP refers a recipient to a specialist for treatment of a specific condition, it is appropriate for the specialist to share a copy of the PCP's written referral/authorization for additional services that may be required in the course of treating **that** condition.

Examples:

- An oncologist has received a written referral/authorization from the PCP to provide treatment to his CommunityCARE 2.0 recipient. During the course of treatment, the oncologist sends a recipient to the hospital for a blood transfusion. The oncologist should send the hospital a copy of the written referral/authorization received from the PCP. **The hospital SHOULD NOT require a separate referral/authorization from the PCP for the transfusion.**

  However, if the oncologist discovers a **new** condition not related to the condition for which the original referral/authorization was written, and that new condition requires the services of a different specialist, the PCP must be advised. The PCP would then determine whether the recipient should be referred for the new condition.

- The PCP refers his CommunityCARE 2.0 recipient to a surgeon for an outpatient procedure and sends the surgeon a written referral/authorization. The surgeon must provide a copy of that written referral/authorization to any other provider whose services may be needed during that episode of care (i.e. DME, Home Health, and anesthesia).

Recipients **may not** be held responsible for claims denied due to provider errors or failure to follow Medicaid policies/procedures, such as failure to:

- **Obtain a PCP referral/authorization**,
- Obtain prior authorization or pre-certification,
- Timely file, or
- Use the correct third party liability (TPL) carrier code, etc.

(See Appendix A for web address to access specific CommunityCARE program and provider information)