

Request to Extend the Rhode Island 1115
Research and Demonstration Waiver
Project No. 11-W-00242/1

The Rhode Island 1115 Waiver
Extension Request



January 2013

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SECTION I. PROGRAM DESCRIPTION

Purpose, Goals, and Objectives

In June 2008, Rhode Island submitted to the Centers for Medicare and Medicaid Services (CMS) a proposal for an 1115 Waiver Demonstration entitled the “Global Consumer Choice Compact.” The Demonstration is scheduled to end on December 31, 2013. This proposal reflects a request to extend the current Demonstration under Section 1115(e) of the Social Security Act (the Act). Rhode Island requests a five-year extension period, beginning January 1, 2014 and ending December 31, 2018. A five-year extension is requested as we believe the proposal meets the definition of a waiver under section 1915(h)(2)(A) of the Act in that it provides medical assistance for dual-eligible individuals.¹

When Rhode Island first proposed the Demonstration, the State was experiencing significant economic distress. One of the explicit reasons the State pursued the original waiver was to attempt to rein in spending on the Medicaid program.

In the four years of implementation of the current 1115 waiver, there has not been significant change in Rhode Island’s economic outlook. While there have been small improvements, the unemployment rate is the second highest in the country and access to affordable housing is still a challenge.² The composition of the State’s population has and will continue to impact our ability to address economic conditions. According to a report for The New England Council, the greatest population growth from 2011 to 2016 will be in persons aged 65 or older. The age cohort 25-44 is estimated to increase modestly while the cohort 45 – 64 is estimated to decrease at the same rate. While the number of working age adults will stay relatively constant, the increase in older people may reduce tax revenues and increase demand for publicly-financed services.³

The need to reform the Medicaid program so that it is a cost-effective and sustainable investment still exists. We believe the 1115 Waiver is an important and powerful tool the State can use to achieve our goals. This extension request seeks to continue the existing Demonstration with some changes we believe improve the Program.

The original proposal posited that the restrictions the federal government places on State Medicaid Programs are a direct driver of program costs. The State requested increased flexibility to administer the Program in exchange for federal funding certainty.

The federal funding certainty was designed as a cap or limit on the amount of spending the federal government would be expected to provide. Overall spending on the five-year demonstration was capped at \$12.075 billion. This budget neutrality arrangement was different than Rhode Island’s budget neutrality agreements in previous 1115 Waivers in that it was not

¹ The State has submitted to CMS a Category II Waiver Change to implement an integrated managed care delivery system for Medicaid-eligible adults with disabilities and people eligible for both Medicaid and Medicare.

² http://intranet.bryant.edu/resources/files/cei_q2_2012.pdf

³ <http://www.newenglandcouncil.com/assets/RI-Executive-Summary.pdf>

enforced on an annual basis and, more importantly, it placed the State at risk for enrollment or caseload as well as per participant per month cost trends.

Rhode Island's budget neutrality agreement has been described in the media as a "block grant." Generally, a block grant is defined as a lump sum provided by the federal government, usually with an expectation that a State will maintain its initial State financial commitment. Rhode Island has been clear that the cap on federal financing is not, in effect, a block grant. Rhode Island Medicaid expenditures continue to be driven first and foremost by the availability of State general revenue. Federal financing is still triggered by a match to a State general revenue spend.

The discussion and debate on the appropriate financing of Medicaid that was triggered by Rhode Island's budget neutrality arrangement has been an informative and valuable conversation. We believe that the issue should continue to be explored by both states and the federal government. The federal funding cap's specific value and impact to Rhode Island's Medicaid spending, however, has been minimal. The one exception has been our ability to use the additional spending authority that resulted from our budget neutrality arrangement to fund items that are not otherwise included as Medicaid expenditures in Section 1903 of the Act (CNOM).

This extension request seeks to remove the federal funding cap from this Demonstration and replace it with a more traditional budget neutrality arrangement. We look forward to working with CMS to ensure the new arrangement is reasonable and does not jeopardize the State's ability to continue with previously approved or new requests for CNOM expenditures. In those discussions, we would be interested in exploring alternative approaches to Medicaid financing that might include financial incentives for States that meet certain health outcome or process measures.

In addition to the federal funding cap, the other major component of the original Demonstration was the State's request for flexibility. In general, we sought to use the requested flexibility to build a Medicaid program that was guided by a core set of principles:

Administrative Simplification

- Combination of 11 waivers into one waiver authority
- Streamlined waiver amendment process

Consumer Empowerment and Choice

Personal Responsibility

- Development and implementation of an Assessment and Coordination Organization Process
- Development of the Office of Community Programs
- Application of spousal impoverishment rules equally across long-term care settings

Community-based care solutions

- Revise Medicaid Long-term Care clinical eligibility determinations
- Expand services such as Shared Living
- Development of Acute Stabilization Unit
- Expanded access to Assisted Living

Prevention, Wellness and Independence

- Nursing home Transition and Diversion
- Increased use of self-directed care
- Mandatory managed care enrollment

Competition

- Selective Contracting
- Hospital Rate Reform
- Acuity-based adjusted nursing home rates

Pay for Performance

- Managed Care Contracting Provisions

Since the Waiver was approved, these guiding principles have changed as a result of two major developments.

The first is the experience and the lessons we have learned in the actual implementation of these activities:

- 1. Selective contracting, in the way implemented by Rhode Island, has not been effective.*

We were unable to successfully implement a selective contracting approach to durable medical equipment. We will continue to explore alternative approaches to ensuring we are contracting with providers that deliver high quality care in a cost-effective manner.

- 2. The ability to impact the long-term care system requires a broader, more comprehensive approach.*

Our efforts at nursing home diversion and transition have not yet provided the results we expected. We believe that our diversion and transition efforts will be enhanced if we take a broader view of the long-term care system and make efforts to impact people's overall health. It is within this context that we are pursuing an Integrated Care Initiative to serve Medicaid-eligible adults with disabilities and persons eligible for Medicare and Medicaid.

- 3. The effectiveness of managed care approaches is constrained if the scope of included services is narrow.*

While we believe our Rhody Health Partners and Connect Care Choice Program are effective, they do not currently serve all Medicaid populations and do not currently include the full range of Medicaid services. Notably, long term services and supports and populations eligible for those services are not presently in managed care arrangements. A more integrated system will incorporate the full range of services and populations.

- 4. The effectiveness of managed care approaches is limited unless the system at the point of service delivery is impacted.*

Managed care systems add value to the system. Greater value can be realized by joining those benefits with person centered care and point of delivery system enhancements such as the patient centered medical home, integrated primary and behavioral health care, all payer collaboratives, cross provider teams, transition management and alignment of incentives in payment reform.

5. An effective health care system needs to include a broader definition of health

Social determinants play a large role in health outcomes, particularly for our most vulnerable and high cost beneficiaries. An effective health care system needs to recognize those critical factors and integrate them into health care plans and delivery.

6. An increased effort to coordinate information and eligibility assistance across State agencies is still needed.

Coordination of our information and eligibility assistance programs across populations and State agencies needs to be improved. For the consumer, our systems remain fragmented and difficult to understand. Customer service needs to be improved. Rhode Island is committed to consumer empowerment as an important force for improved health outcomes.

The second development that causes us to assess our original guiding principles is the introduction of the Affordable Care Act. The ACA is widely recognized as the most significant change in health care in decades. From the beginning Rhode Island has committed to fully embracing the opportunities the ACA affords.

One of the major goals of the ACA is to ensure as many people as possible have access to and avail themselves of affordable coverage. EOHHS intends to seek General Assembly approval to submit a State Plan Amendment to implement the Medicaid expansion available in the ACA. If approved, childless adults meeting the income guidelines will be Medicaid-eligible in 2014.

The ACA also provides Rhode Island with an opportunity to implement additional options and tools that support the provision and financing of Medicaid home and community-based services and improve consumer outcomes.

As a result of these two developments, we have revised the original guiding principles into the following focus areas that are supported by both the 1115 Waiver Demonstration and the ACA:

Ensure information about services and how to access them is readily available and consistent.

We will have a robust **Consumer Assistance Program** housed at EOHHS that will support and help to coordinate all of the information and referral, options counseling, eligibility assistance, and case management that occurs across the EOHHS agencies. This effort will build on the Assessment and Coordination Office first introduced in the original waiver and will take advantage of the additional opportunities for consumer support in the ACA.

Ensure Medicaid financed services are responsive and appropriate to a person’s medical, functional, and social needs.

Services need to be coordinated across providers and systems. They need to be available and provided timely at the point when they will have the most impact. We need to develop more community-based service alternatives such as “Bridge” for person becoming more vulnerable in the community, Supportive Housing, Housing Retention Services, Emergency Room Diversions and high fidelity wraparound services for children and youth.

Ensure the Medicaid program is coordinated and integrated with other publicly-financed health care

EOHHS was created on December 1, 2005 to facilitate cooperation and coordination among the state departments that administer Rhode Island's health and social service programs. Together we impact the lives of virtually all Rhode Islanders, providing direct services and benefits to over 300,000 citizens while working to protect the overall health, safety and independence of all Rhode Islanders.

The 1115 Demonstration and the ACA provide enhanced opportunities for State agencies to increase interdepartmental cooperation and coordination so that we have more effective and responsive programs. This inter-agency cooperation has been evident in the way we have implemented the CNOM Program.

Ensure the Medicaid program is coordinated with other insurance systems

We will **finance health care services** in ways that support the outcomes we are seeking for our beneficiaries. We will improve the coordination of financing across all EOHHS agencies. We will use managed care as a cost-effective tool to improve access and coordinate care. When we pay directly for services or contract with managed care organizations, we will implement reimbursement methodologies that deliver outcomes, not more services. We will pursue financing methodologies in concert with other payers, such as Medicare, in order to reduce provider burden.

Utilize Information Technology Systems more efficiently

We will use our **technology systems** much more efficiently. The Medicaid program of 2014 will have an automated and accountable eligibility determination system. We have begun enhancing our Medicaid Management Information System. We have begun to supplement our Data Warehouse with additional resources. All these systems will be used to improve the efficiency and results of all our programs.

We will have a dedicated and active **Quality and Evaluation Office** that will ensure any budget initiative, grant, program, or medical benefit actually achieves the results we are seeking. If it does not, we will stop doing it and paying for it. We will publish those results on our website and make it easy for people to understand how the State is spending Medicaid dollars and the effectiveness of those efforts. This effort will be supported by our recently received grant to implement quality measures for adult health.

While the ACA does provide many tools to help us achieve our goals, we continue to need the authority of the 1115 Waiver to continue initiatives and to pursue new efforts. This extension

request seeks to continue all existing Waiver and Expenditure Authorities and outlines new initiatives we will be pursuing and the appropriate waiver or expenditure authority requested for implementation.

SECTION II. DEMONSTRATION ELIGIBILITY

Question #1:

Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included). Please refer to Medicaid Eligibility Groups: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf> when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public:

ELIGIBILITY GROUPS UNDER THE APPROVED STATE PLAN AS OF NOVEMBER 1, 2008

Categorically Needy Medicaid Eligibility Groups

Mandatory Categorically Needy Coverage Groups

<i>Medicaid Eligibility Groups</i>	<i>Income and Resource Standards and/or Other Qualifying Criteria</i>	<i>Expenditure and CMS 64 Eligibility Group Reporting</i>
§1931 low income families with children §1902(a)(10)(A)(i)(I); §1931	<i>Income:</i> Up to 110 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Children receiving IV-E payments (IV-E foster care or adoption assistance) §1902(a)(10)(A)(i)(I)	<i>Income:</i> Up to 100 percent of FPL <i>Resource:</i> No resource test	Budget Population 4 CSHCN
Individuals who lose eligibility under §1931 due to employment §1902(a)(10)(A)(i)(I); §402(a)(37); §1925	<i>Income:</i> Up to 110 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Individuals who lose eligibility under §1931 because of child or spousal support §1902(a)(10)(A)(i)(I); §406(h)	<i>Income:</i> Up to 110 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Individuals participating in a work supplementation program who would otherwise be eligible under §1931 §1902(a)(10)(A)(i)(I); §482(e)(6)	<i>Income:</i> Up to 110 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Individuals who would be eligible AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972) 42 CFR 435.114	<i>Income:</i> Up to 110 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care

Disabled children no longer eligible for SSI benefits because of a change in definition of disability §1902(a)(10)(A)(i)(II)(aa)	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000	Budget Population 1 ABD no TPL
Individuals under age 21 eligible for Medicaid in the month they apply for SSI §1902(a)(10)(A)(i)(II)(cc)	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000	Budget Population 1 ABD no TPL
Qualified pregnant women §1902(a)(10)(A)(i)(III); §1905(n)(1)	<i>Income:</i> Up to 100 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Qualified children §1902(a)(10)(A)(i)(III); §1905(n)(2)	<i>Income:</i> Up to 100 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Poverty level pregnant women and infants §1902(a)(10)(A)(i)(IV)	<i>Income:</i> up to 185 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Qualified family members §1902(a)(10)(A)(i)(V)	<i>Income:</i> Up to 100 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Poverty level children under age 6 §1902(a)(10)(A)(i)(VI)	<i>Income:</i> Up to 133 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Poverty level children under age 19, born after September 30, 1983 (or, at	<i>Income:</i> Up to 100 percent of FPL	Budget Population 3 RIte Care
State option, after any earlier date) §1902(a)(10)(A)(i)(VII)	<i>Resource:</i> No resource test	
Newborns deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant §1902(e)(4)	<i>Income:</i> up to 185 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Pregnant women who lose eligibility receive 60 days coverage for pregnancy related and post partum services §1902(e)(5)	<i>Income:</i> <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Pregnant women who lose eligibility because of a change in income remain eligible 60 days post partum §1902(e)(6)	<i>Income:</i> up to 185 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Poverty level infants and children who while receiving services lose eligibility because of age must be covered through an inpatient stay §1902(e)(7)	<i>Resource:</i> No resource test	Budget Population 3 RIte Care

Individuals receiving SSI cash benefits §1902(a)(10)(A)(i)(II)	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
Disabled individuals whose earning exceed SSI substantial gainful activity level §1619(a)	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
Disabled individuals whose earning are too high to receive SSI cash benefits §1902(a)(10)(A)(i)(II)(bb); §1905(q); 1619(b)	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
Pickle: individuals who would be eligible for SSI if Title II COLAs were deducted from income §503 of P.L. 94-566; §1939(a)(5)(E)	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
Disabled widows and widowers §1634(b); §1939(a)(2)(C)	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
Disabled adult children who lose SSI due to OASDI §1634(c); §1939(a)(2)(D)	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
Early widows/widowers §1634(d); §1939(a)(2)(E)	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
Individuals ineligible for SSI/SSP because of requirements prohibited under Medicaid 42 CFR 435.122	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
Qualified Medicare Beneficiaries §1902(a)(10)(E)(i); §1905(p)(1)	<i>Income:</i> 100 percent of FPL <i>Resource:</i> \$4,000 single \$6,000 couple	Budget Population 2 ABD TPL
Qualified disabled and working individuals (defined in §1905(s)); not otherwise eligible for Medicaid §1902(a)(10)(E)(ii)	<i>Income:</i> 200 percent of FPL <i>Resource:</i> \$4,000 single \$6,000 couple	Budget Population 2 ABD TPL
Specified Low-Income Medicare Beneficiaries §1902(a)(10)(E)(iii)	<i>Income:</i> >100 percent but =<120 percent of FPL <i>Resource:</i> \$4,000 single \$6,000 couple	Budget Population 2 ABD TPL
Qualified Individuals; not otherwise eligible for Medicaid §1902(a)(10)(E)(iv)	<i>Income:</i> >120 percent but =<135 percent of FPL <i>Resource:</i> \$4,000 single \$6,000 couple	Budget Population 2 ABD TPL

Optional Categorically Needy Coverage Groups

Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria	Expenditure and CMS 64 Eligibility Group Reporting
Individuals who are eligible for but not receiving IV-A §1902(a)(10)(A)(ii)(I)	<i>Income:</i> Up to 110 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Individuals who are eligible for IV-A cash assistance if State did not subsidize child care §1902(a)(10)(A)(ii)(II)	<i>Income:</i> Up to 110 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Children under age 1	<i>Income:</i> Up to 250 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Children under 21, (or at State option, 20, 19, or 18) who are under State adoption agreements §1902(a)(10)(A)(ii)(VIII)	<i>Income:</i> Title IV-E (§1931 Standard; Up to 110 percent of FPL) <i>Resource:</i> Title IV-E (§1931 Standard; no resource test)	Budget Population 4 CSHCN
Independent foster care adolescents §1902(a)(10)(A)(ii)(XVII)	<i>Income:</i> 110 percent of FPL <i>Resource:</i> No resource test	Budget Population 4 CSHCN
Optional Targeted Low Income Children §1902(a)(10)(A)(ii)(XIV); §1905(u)(2)	<i>Income:</i> =< 250% <i>Resource:</i> No resource test	Budget Population 7 XXI Children
Individuals under 21 or at State option, 20, 19, 18, or reasonable classification 1 §1905(a)(i); 42 CFR 435.222	<i>Income:</i> Up to 110 percent of FPL <i>Resource:</i> No resource test	Budget Population 4 CSHCN
Individuals who are eligible for but not receiving SSI or State supplement cash assistance §1902(a)(10)(A)(ii)(I)	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
Individuals who would have been eligible for SSI or State supplement if not in a medical institution §1902(a)(10)(A)(ii)(IV)	<i>Income:</i> 100 % SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
Special income level group: individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of SSI income standard §1902(a)(10)(A)(ii)(V)	<i>Income:</i> 300 percent of SSI Federal benefit level <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL

Aged or disabled individuals whose SSI income does not exceed 100% of FPL §1902(a)(10)(A)(ii)(X)	<i>Income:</i> =< 100 percent FPL <i>Resource:</i> \$4,000 individual \$6,000 couple	Budget Population 1 ABD no TPL
Individuals receiving only an optional State supplement payment which may be more restrictive than the criteria for an optional State supplement under Title XVI §1902(a)(10)(A)(ii)(XI)	<i>Income:</i> based on living arrangement can not exceed 300% SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
BBA working disabled group: Working disabled individuals who buy in to Medicaid §1902(a)(10)(A)(ii)(XIII)	<i>Income:</i> Up to 250 percent FPL <i>Resource:</i> Up to \$10,000 individual Up to \$20,000 couple	Budget Population 1 ABD no TPL
Uninsured women, under 65, who are screened for breast or cervical cancer under CDC program and not eligible for Medicaid §1902(a)(10)(A)(ii)(XVIII)		Budget Population 14 BCCTP
TEFRA section 134 children: disabled individuals age 18 or under who require an institutional level of care; care can be provided outside the institution; estimated amount for home care can be no more than estimated amount for institutional care §1902(e)(3)	<i>Income:</i> 300 percent of SSI Federal benefit level <i>Resource:</i> \$2,000	Budget Population 4 CSHCN
Presumptive eligibility for women who are screened for breast or cervical cancer under CDC program §1920B		Budget Population 14 BCCTP

Medically Needy Medicaid Eligibility Groups

Mandatory Medically Needy Coverage Groups

<i>Medicaid Eligibility Groups</i>	<i>Income and Resource Standards and/or Other Qualifying Criteria</i>	<i>Expenditure and CMS 64 Eligibility Group Reporting</i>
Individuals under 18 who would be mandatorily categorically eligible except for income and resources §1902(a)(10)(C)(ii)(I)	<i>Income:</i> 133 ¹ / ₃ percent of §1931 income standard <i>Resource:</i> Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100	Budget Population 3 RItE Care

Pregnant women who would be categorically eligible except for income and resources §1902(a)(10)(C)(ii)(II)	<i>Income:</i> 133 ¹ / ₃ percent of §1931 income standard <i>Resource:</i> Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100	Budget Population 3 RIte Care
Newborns, who except for income and resources would be eligible as categorically needy, deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant §1902(a)(10)(C); §1902(e)(4)	<i>Income:</i> 133 ¹ / ₃ percent of §1931 income standard <i>Resource:</i> Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100	Budget Population 3 RIte Care
Pregnant women who lose eligibility received 60 days coverage for pregnancy-related and post partum services §1902(a)(10)(C); §1902(e)(5)	<i>Income:</i> 133 ¹ / ₃ percent of §1931 income standard <i>Resource:</i> Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100	Budget Population 3 RIte Care
All individuals under 21 or at State option, 20, 19, or 18 or reasonable classifications who would not be covered under mandatory medically needy group of individuals under 18 §1902(a)(10)(C); §1905(a)(i) ¹	<i>Income:</i> 133 ¹ / ₃ percent of §1931 income standard <i>Resource:</i> Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100	Budget Population 3 RIte Care
Specified relatives of dependent children who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(ii)	<i>Income:</i> 133 ¹ / ₃ percent of §1931 income standard <i>Resource:</i> Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100	Budget Population 3 RIte Care

Optional Medically Needy Coverage Groups

<i>Medicaid Eligibility Groups</i>	<i>Income and Resource Standards and/or Other Qualifying Criteria</i>	<i>Expenditure and CMS 64 Eligibility Group Reporting</i>
Aged individuals who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(iii)	<i>Income:</i> 133 ¹ / ₃ percent of §1931 income standard <i>Resource:</i> Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100	Budget Population 1 ABD no TPL

Blind individuals who are ineligible as categorically needy §1902(a)(10)(C);§1905(a)(iv)	<i>Income:</i> 133 ¹ / ₃ percent of §1931 income standard <i>Resource:</i> Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100	Budget Population 1 ABD no TPL
Disabled individuals who are ineligible as categorically needy §1902(a)(10)(C); §1902(v)	<i>Income:</i> 133 ¹ / ₃ percent of §1931 income standard <i>Resource:</i> Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100	Budget Population 1 ABD no TPL
TEFRA section 134 children: disabled individuals age 18 or under who require an institutional level of care; care can be provided outside the institution; estimated amount for home care can be no more than estimated amount for institutional care §1902(e)(3)	<i>Income:</i> 300 percent of SSI Federal benefit level <i>Resource:</i> \$4,000	Budget Population 4 CSHCN

¹The State covers this group up to age 21 in the following classifications: (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are (a) in foster homes and (b) in private institutions; (2) Individuals placed in foster homes or private institutions by private, non-profit agencies; (3) individuals in nursing facilities; and (4) individuals in ICFs/MR.

ELIGIBILITY GROUPS UNDER THE DEMONSTRATION

Groups That Could Be Covered Under the State Plan But Gain Eligibility Through §1115 Demonstration

<i>Medicaid Eligibility Groups</i>	<i>Income and Resource Standards and/or Other Qualifying Criteria</i>	<i>Expenditure and CMS 64 Eligibility Group Reporting</i>
Parents/Caretakers with Children	<i>Income:</i> Above 110% to 175% FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
Pregnant Women	<i>Income:</i> Above 185% to 250% FPL <i>Resource:</i> No resource test	Budget Population 6 RIte Care
Children Under 6	<i>Income:</i> Above 133% to 250% FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care

Children Under 19	<i>Income:</i> Above 100% to 250% FPL <i>Resource:</i> No resource test	Budget Population 3 RIte Care
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Expansion Groups Under §1115 Demonstration

<i>Medicaid Eligibility Groups</i>	<i>Income and Resource Standards and/or Other Qualifying Criteria</i>	<i>Expenditure and CMS 64 Eligibility Group Reporting</i>
Women who lose Medicaid eligibility 60 days postpartum received 24 months of family planning services	<i>Income:</i> Up to 200% FPL <i>Resource:</i> No resource test	Budget Population 5 EFP
Children and families in managed care enrolled in RIte Care (children under 19 & parents) when the parents have behavioral health conditions (substance abuse/mental illness) that result in their children being placed in temporary State custody.	<i>Income:</i> up to 200% FPL <i>Resource:</i>	Budget Population 8 Substitute Care
Children with special health care needs (as an eligibility factor) who are 21 and under who would otherwise be placed in voluntary state custody—residential diversion	<i>Income:</i> 300 percent of SSI <i>Resource:</i> no resource limit	Budget Population 9 CSHCN not voluntarily placed in State custody
Individuals 65 and over At risk for LTC who are in need of home and community-based services (state only group).	<i>Income:</i> at or below 200% of the FPL <i>Resource Test:</i> No resource test	Budget Population 10 Elders at risk for LTC
Categorically Needy Individuals under the State Plan receiving HCBW services & PACE-like participants highest need group	Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under 42 CFR 435.217, 435.726 and 435.236 of the federal regulations and section 1924 of the Social Security Act, if the State had 1915(c) waiver programs.	Budget Population 11 217 & PACE like Categorically needy Highest

Categorically needy individuals under the State Plan receiving HCBW services & PACE-like participants High need group	Use institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner as specified under 42 CFR 435.217, 435.236, and 435.726 of the federal regulations and 1924 of the Social Security Act, if the State had 1915(c) waiver programs.	Budget Population 12 217 & PACE like Categorically needy High
Medically needy under the State Plan receiving HCBW services in the community (high and highest group) Medically needy PACE-like participants in the community	Apply the medically needy income standard plus \$400 and use institutional eligibility rules, including the application of spousal impoverishment eligibility rules.	Budget Population 13 217 & PACE like Medically needy High & Highest
Adults with disabilities served by the Office of Rehabilitation Services (ORS) who are not eligible for Medicaid, but may become so if these services are not provided	Income: up to 300% of SSI	Budget Population 15 Adults with disabilities at risk for long-term care.
Services for uninsured adults w/mental illness and/or substance abuse problems who are at risk for a hospital level of care	Income: up to 200% of the FPL	Budget Population 16 Uninsured adults with mental illness
Medicaid eligible youth who are at risk for placement in residential treatment facilities and or in patient hospitalization	Income: up to 250% FPL Resource	Budget Services 4 At risk youth Medicaid eligible
Children under age 18 who are at risk for Medicaid or institutional care not eligible for Medicaid	Income: up to 300% of SSI for child Resource:	Budget Population 17 Youth at risk for Medicaid
HIV Positive individuals who are otherwise ineligible for Medicaid	Incomes: at or below 200% of the FPL	Budget Population 18 HIV
Adults –ages 19-64 – who are unable to work due to a variety of health conditions, but do not qualify for disability benefits.	Income: up to 200% FPL Resource:	Budget Population 19 Non-working disabled adults

Question #2:

Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan:

The State will comply with the MAGI standards and methodologies for MAGI populations as required under the Affordable Care Act. Eligibility standards and methodologies for non-MAGI populations will remain the same with the exception as noted in the response to question 6 below.

Hospitals that elect to implement presumptive eligibility are required to become Navigators and use the online portal to apply for Medicaid eligibility on behalf of their patients.

Question #3:

Specify any enrollment limits that apply for expansion populations under the Demonstration:

Not applicable

Question #4:

Provide the projected number of individual who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs:

Enrollment projections are currently being developed.

Question #5:

To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State):

No change anticipated from current waiver.

The State utilizes spousal impoverishment rules under Section 1924. Spousal impoverishment rules apply to an individual who is in a medical institution or nursing facility or who would be in a medical institution or nursing facility but for the provision of home or community-based services and is married to a spouse who is not in a medical institution or nursing facility.

Question #6:

Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013):

Existing eligibility procedures under the Waiver continue to apply. In addition, the State seeks the following waiver for expedited long-term care services.

Expedited Long Term Care Services: The State is seeking a waiver to accept self attestation of the financial eligibility criteria for new Long Term Care (LTC) applicants for a period of up to ninety (90) days. The individual would be required to complete the LTC Clinical and Financial Application for LTC services. The individual would need to meet the Clinical Eligibility criteria and provide a self-attestation of the LTC financial criteria to receive a limited benefit package of community based LTSS for up to 90 days pending the determination of the full LTC financial application. The limited benefit package would include a maximum of ten (10) hours weekly of person care/homemaker services and/or a maximum of three (3) days weekly of Adult Day Care Services. Upon determination of the approval of the full LTC financial application, the individual would receive the full LTC benefit package. The limited community-based LTSS services would be available for up to ninety (90) days or until the eligibility for LTC decision is rendered, which ever comes first. This will enable the individual to be maintained in the community and avoid costly institutional care.

Continuity of Coverage Between Exchange and Medicaid: Ensure continuity of coverage for persons who lose eligibility for Medicaid or CHIP and as a result become eligible for a Qualified Health Plan (QHP) through the Exchange by retaining Medicaid or CHIP eligibility until enrollment in a QHP begins. This will help ensure continuity of care for these individuals during this transition period.

Question #7:

If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014:

The State has completed the draft MAGI conversion template and will adhere to MAGI conversion methodology guidance for all applicable populations as it is released from CMS. The State will work with CMS to implement the income conversion methodology as required. The State will follow its Verification Plan and Reasonable Compatibility standards as approved by CMS in determining MAGI eligibility.

The State of Rhode Island intends to carry forward all existing eligibility groups from the previous waiver. In addition, through the State Plan, Rhode Island intends to:

- Expand Medicaid eligibility for “Independent Former Foster Children” from age 21 to age 26 as required by the Affordable Care Act,
- Expand Medicaid eligibility for adults with income less than 133% of the Federal Poverty Level, pending authorization from the Rhode Island General Assembly and

SECTION III. DEMONSTRATION BENEFITS

INTRODUCTION

The intent of this section is to outline the benefits provided under this demonstration extension. The details provided are intended to carry over all the benefits outlined in the prior demonstration while describing additional benefits the State is contemplating. To the extent that the State complies with the provisions of this extension to make changes in the benefit package, the State has the flexibility to provide customized benefit packages to beneficiaries based on medical need. All State Plan amendments will continue to be applicable and remain in-force.

Question #1:

Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

Benefits are the full scope of benefits set forth in the approved State plan, unless specified in the Demonstration. Benefits are delivered through managed care organizations or managed care delivery systems, with the exception of certain services paid by the State on a fee-for-service basis.

Question #3:

If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration:

The State intends to continue the benefits provided to the eligibility groups outlined in the prior demonstration as identified in the special terms and conditions, Attachment A.

Question #4:

If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

The state does not intend to use benchmark-equivalent coverage for a population.

Question #5:

In addition to the Benefit Specifications and Qualifications form, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan:

Rhode Island will continue to use the additional flexibility afforded by the demonstration to further redesign the State's Medicaid program to provide cost-effective services that will ensure beneficiaries receive the appropriate services in the least restrictive and most appropriate setting during the Demonstration period.

The State will continue to use Program Flexibility that provides the State authority and the type of administrative processes for making changes in the Medicaid program during the Demonstration period. The State was awarded flexibility to demonstrate that it can provide Medicaid beneficiaries access to the most appropriate services while attempting to preserve the overall scope of eligibility and coverage.

POTENTIAL NEW SERVICES UNDER CONSIDERATION

The State is in the process of researching and reviewing services that are designed to provide more effective and less costly alternatives to traditional Medicaid-funded services, such as emergency department visits and hospitalizations. The State looks forward to working with CMS regarding the ability to implement one or more of the following during the waiver extension period.

Extended Family Planning

To better achieve the goals of the Extended Family Planning Program, which are to ensure optimal inter-birth intervals and optimal maternal and child health for Medicaid recipients, and reduce the complexity of administration the Extended Family Planning Benefit will include the following categories of service:

1. New patient or Established patient office visits
2. Screening, testing, counseling, and treatment (and, where applicable, vaccination) for sexually transmitted infections, including:
 - a. Gonorrhea
 - b. Chlamydia
 - c. HPV
 - d. Genital Herpes simplex
 - e. Trichomonas
 - f. Syphilis
 - g. Hepatitis B and C
 - h. HIV (screening and counseling only)
3. Screening and treatment for urinary tract infection
4. Age appropriate preventive screening, not covered by Breast and Cervical Cancer screening program, as recommended by the US Preventive Services Task Force.
5. FDA approved contraceptive pharmaceuticals and devices, including condoms, and their associated insertion and removal procedure codes. Also including facility fees for outpatient surgical procedures.
6. Pre-conceptional counseling
7. Folic acid supplements
8. Tobacco cessation counseling and nicotine replacement therapy

These categories, while remaining within the relatively narrow definition of Family Planning Services, help avoid a short interbirth interval that can lead to adverse consequences for the subsequent pregnancy. Providing these services to the parent of a young infant is a cost effective method to prevent subsequent low birthweight births in the Medicaid program, and to insure adequate maternal resources are available to the Medicaid-eligible child born during the prior eligibility period. All other aspects of the Extended Family Planning Program outlined in the prior demonstration remain in full effect in the extension period.

Waiver of Institutions for Mental Disease (IMD) Exclusion

Residential substance abuse treatment is an evidence-based and clinically effective treatment milieu for members who are diagnosed with substance use disorders. In Rhode Island, there are five residential providers in six different locations statewide. During state fiscal year 2012, approximately 1300 people were served by these providers, with 1500 total stays. Of the 1500 stays approximately 400 stays were for Medicaid eligible clients. Because these treatment facilities have more than 16 beds, they are defined as Institutions for Mental Disease (IMDs), and therefore payment for these services cannot be rendered by Medicaid fee-for-service programs.

As defined in §1905 (i) of the Social Security Act, and Chapter 42 of the Code of Federal Regulations Section 435.1009, Institutions for Mental Disease (IMDs) are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness. Federal Medicaid matching payments are prohibited for IMDs with a population between the ages of 22 and 64.

EOHHS requests a waiver of this section of the Act, in order to receive federal matching payments for substance abuse treatment services in facilities with greater than 16 beds.

Wellness Benefit

Incentives to reward healthy behaviors and life style choices have been successful in motivating recipients to make choices that contribute to positive health and well being, thus reducing expenditures for services such as hospitalizations, emergency department visits and specialty care. The State included rewards for consumer behavior in its Communities of Care Program, developed as a part of the CMS Emergency Department Diversion grant awarded in April 2008. Preliminary evaluation results indicate the rewards initiative was instrumental in encouraging and reinforcing adherence to program goals, and led to significant reductions in utilization of emergency department visits. The State would like to reserve the right to include a wellness benefit to reward designated recipients for participation in programs such as weight loss, smoking cessation, stress management, etc.

Peer Mentoring

Peer mentoring is a service available to eligible participants who are transitioning into the community from a nursing home setting. It is an individually designed service intended to improve the participant's self sufficiency, self reliance, and ability to access needed services, goods and opportunities in the community. Peer mentors are individuals who

have had experience in the long term care delivery system and who receive additional training in how to assist individuals in acclimating and adapting to community living subsequent to a prolonged nursing home stay.

Peer Specialist/Peer Navigator

Peer specialists and peer navigators are similar to peer mentors with the exception that they are providing supports and services to individuals in a broad array of community-based settings rather than individuals adapting to life outside of a nursing home setting. Peer Navigators have been successfully used in the Communities of Care Initiative to help members learn about and understand appropriate alternatives to emergency department visits. The State reserves the right to adopt the use of peer navigators/peer specialists in a variety of community based settings to assist enrollees in navigating the health care delivery system and making appropriate and safe health care utilization choices.

Pain Management

A pain management benefit, which was approved using a category II change, was incorporated into the Communities of Care Program in April 2012. This benefit enhancement is targeted to Communities of Care members who experience chronic pain and have been diagnosed with a limited set of conditions, including chronic back and/or neck pain, migraines and fibromyalgia. The program includes evidence-based clinical practice guidelines, an integrated treatment plan, and the integration of complementary therapies such as chiropractic, acupuncture, and massage therapy, when diagnostically appropriate. Ongoing collaboration and communication with the enrollee's Primary Care Provider and (when appropriate) behavioral health provider is a requirement. Preliminary results indicate this pain management approach has been successful in reducing emergency department utilization. Under this Waiver Extension, the State reserves the right to expand Pain Management to designated additional populations experiencing chronic pain.

STOP – Sobering Treatment Opportunity Program

A large driver of Emergency Room utilization is clients who are “chronic inebriates”. First responders (e.g. police, fire and rescue) are required to bring inebriated individuals to hospital emergency rooms, if they are not in police custody for committing a crime. EOHHS is requesting authority to provide services in an alternative treatment setting, which provides a combination of a short-term recovery program, detoxification services and/or referral arrangements. This program is called The Sobering Treatment Opportunity Program (STOP).

A clinical and functional assessment is performed prior to admission to assure that the client is appropriate for STOP. A history and physical exam is administered by the RN team member, using a standardized assessment tool, as well as blood screen, to determine if other issues are contributing to the client's condition. Screening to identify potential mental health issues will be performed as well using evidence based suicide/mental health assessment tool, where appropriate.

Licensed clinical staff will be available at the facility to monitor medical issues, prescribe medications, perform minor primary care services, and facilitate transfer to the hospital, whenever necessary. Peer specialists will be utilized to help engage clients and guide them through the steps of participation, recovery and ongoing support services in the program. Length of stay with STOP is typically 48 to 72 hours.

Once a member has completed detoxification, the peer specialist at the STOP center will refer the client for outpatient and/or residential treatment as appropriate. The peer specialist/sober coach will conduct the appropriate follow up to coordinate appointments for the client, and assist client in keeping appointments.

EOHHS is requesting authorization to use member incentives to encourage clients to engage in ongoing substance abuse treatment, upon discharge from STOP.

Evidence Based Treatment for Children

The State is working closely with the Department of Children, Youth and Families to ensure that children in or at risk of entering DCYF custody have access to a range of in-home behavioral health programs that have been shown to be effective in decreasing problem behaviors, and increasing developmentally appropriate prosocial behavior. Examples of evidence based treatment programs include but are not limited to Brief Strategic Family Therapy, Functional Family Therapy and Multi Systemic Therapy. Specific interventions included in these programs are established behavioral health modalities such as child and family therapy, group therapy, parental training, and intensive care management and coordination. Services are provided by licensed clinicians with the exception of the clinical care coordination and treatment supportive services which are provided by a bachelor's level provider working under the supervision of a licensed clinician.

Intensive Care Management

The State is currently working to obtain CMS approval to develop an Integrated Care Initiative to integrate care and financing for individuals with both Medicare and Medicaid. The State reserves the right to seek approval for an expanded intensive care management benefit to be provided to these beneficiaries. The details of this benefit will be delineated in the Integrated Care Initiative Proposal to be submitted to CMS.

Community Based Support Services/Supportive Housing

EOHHS requests a waiver of comparability to provide certain Medicaid eligible clients with a set of community support services. Provision of these services will result in a reduction in the need for medical interventions. These clients have health conditions (e.g., illnesses, behavioral health conditions or functional impediments) that require long term interventions that are restorative and optimize quality of life in community-based settings. In addition, these clients require support to maintain stable housing.

This target population includes individuals who are frequent users of or at risk of becoming frequent users of high-cost emergency or hospital care. Housing instability is

one barrier to better health, and health outcomes will not meaningfully improve without support to maintain housing.

With expanded Medicaid eligibility under the Affordable Care Act, the landscape for supportive housing programs has changed as a majority of homeless persons are now eligible for Medical Assistance. Furthermore, Rhode Island identified obtaining and maintaining housing as a critical goal for Medicaid reform in our state.

The State will designate beneficiaries who it believes would most appropriately from this benefit.

EOHHS is requesting a waiver of comparability in order to provide a set of services, to be delivered in a home-like setting. These services are individualized based on client needs and includes health care coordination (including mental health and substance use), assistance navigating social service and benefit systems, and housing maintenance support. The list that follows details these services:

- Care Management or Service Coordination
 - Assessment
 - Services intake
 - Assessment-identifying client need
 - Gathering required documents for eligibility determination
 - Arranging for further testing and evaluation
 - Conducting reassessments
 - Documenting assessment activities
 - Service Plan Development:
 - Service Plan Development with client/tenant
 - Writing service plan
 - Determining who should provide services
 - Obtaining signatures
 - Update and review service plan
 - Documenting service plan development
 - Referral, Monitoring, Follow-up:
 - Referrals to other ancillary services
 - Referral and related activities
 - Assist in connecting to services
 - Coordination of services identified in service plan
 - Monitoring and evaluation
 - Documenting referral, monitoring and follow-up
 - Personal advocacy
- Medication management/monitoring
 - Harm Reduction strategies
 - Substance abuse counseling
 - Peer counseling, mentoring
 - Education about mental illness
 - Psychotropic medication education

- Recovery readiness
 - Relapse prevention
- Routine medical care, medication management, vision, dental, HIV/AIDS services
 - Medication set-up
 - Medication coordination
 - HIV/AIDS/STD education
 - End of life planning
- Entitlement assistance/benefits counseling
 - Entitlement and benefits counseling
 - Application for income assistance and the Supplemental Nutrition Assistance Program
 - Application for health benefits, including Medical Assistance and specific programs funded through Medical Assistance
 - Referral to legal advocacy and assistance with appeals when needed to appeal a denial of public benefits
 - Budgeting and financial education
- New tenant orientation/move-in assistance
 - Finding housing
 - Applying for housing
 - Landlord advocacy
 - Securing household supplies, furniture
 - Tenancy supports
 - Eviction prevention
- Outreach and in-reach services
 - Identifying and engaging with un-served, under-served individuals, and poorly-served individuals
 - Connecting individuals with mainstream services
- Independent living skills training
 - Nutrition education
 - Cooking/meal prep
 - Personal hygiene and self-care
 - Housekeeping
 - Apartment safety
 - Using public transportation
- Job Skills training/education
 - School connections
 - Access to Social Support
 - Truancy intervention
 - Access to academic support
 - Opportunities/access to GED, post-secondary training
 - Supported employment
 - Childcare (we do not provide but connect people to resources)
- Domestic Violence intervention
 - Domestic Abuse Services
 - Crisis planning, intervention

- Child Protection assessment, follow-up
- Referral to Legal Advocacy
- Training in personal and household safety
- Crisis intervention-clinic based or mobile crisis
- Support groups Self-determination/Life satisfaction
 - Grief counseling
 - Development of recovery plans
 - Group therapy
 - Recreation
 - Social Support
 - Community involvement/integration
 - Parenting supports and mentoring
 - Peer monitoring/support
 - Conflict resolution/mediation training
- Respite Care
- Individual counseling
- Discharge planning
- Reengagement

Question #6:

In addition, please complete the <http://Medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf>, and the: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf>

Long Term Services and Support will continue to be provided. The services to be provided during the extension period at reference in Attachment 2.

Question #7:

Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration:

The State plans no changes to its authority regarding the Premium Assistance Program in this extension period.

Special Terms and Conditions Attachment A: SERVICES³

State Plan Services as of 11/1/2008 – Any State Plan Services added after 11/1/2008 are also included in this extension.

Service	Description
Inpatient Hospital Services	Mandatory 1905(a)(1)
Outpatient Hospital Services	Mandatory 1905(a)(2)
Rural health clinic services	Mandatory 1905(a)(2)
FQHC services	Mandatory 1905(a)(2)
Laboratory and x-ray services	Mandatory 1905(a)(3)
Diagnostic Services	Optional 1905(a)(13)
Nursing Facility Services for 21 and over	Mandatory 1905(a)(4)
EPSDT	Mandatory 1905(a)(4)
Family Planning	Mandatory 1905(a)(4)
Physicians' services	Mandatory 1905(a)(5)
Medical and Surgical services furnished by a dentist	Mandatory 1905(a)(5)
Podiatrists' services	Optional 1905(a)(6)
Optometrists' services	Optional 1905(a)(6)
Intermittent or part-time nursing services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
Home health aide services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
Medical supplies, equipment, and appliances	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
Physical therapy; occupational therapy; speech pathology; audiology provided by a home health	Optional 1902(a)(10)(D) 42 CFR 440.70
Clinic Services	Optional 1905(a)(9)
Dental Services	Optional 1905(a)(10)
Prescribed Drugs	Optional 1905(a)(12)
Non-Prescription Drugs	Optional 1927(d)
Dentures	Optional 1905(a)(12)
Prosthetic Devices	Optional 1905(a)(12)
Eyeglasses	Optional 1905(a)(12)
Preventive Services	Optional 1905(a)(13)
Rehabilitative Services	Optional 1905(a)(13)
Services for individuals over age 65 in IMDs	Optional 1905(a)(14)
Intermediate Care Facility Services	Optional 1905(a)(15)
Inpatient psychiatric facility services for under 22	Optional 1905(a)(16)
Nurse-midwife services	Mandatory 1905(a)(17)
Hospice Care	Optional 1905(a)(18)
Case Management Services and TB related services	Optional 1905(a)(19)
Extended services for pregnant women	Optional 1902(e)(5)
Certified pediatric or family nurse practitioners	Mandatory 1905(a)(21) is a mandatory service
Nursing facility services for patients under 21	Optional 1905(a)(28) 42 CFR 440.170
Personal care services in recipient's home	Optional 1905(a)(28) 42 CFR 440.170
Transportation	Optional as a medical service 1905(a)(28) 440.170 required as an administrative function 42 CFR 431.53
Primary care case management services	Optional 1905(a)(25)

PACE services	Optional 1905(a)(26)
Emergency services for certain legalized aliens and undocumented aliens	Mandatory 1903(v)(2)(A)

³ These services can be modified through a Category II process up to DRA benchmark benefit flexibility levels and then the State must pursue a Category III change.

Special Terms and Conditions Attachment A1: Demonstration Only Benefits

These benefits are not provided under the Rhode Island Medicaid State Plan, but only under the Demonstration and apply to all delivery systems in this Demonstration extension. Any additional Demonstration Only Benefits added since the last Demonstration are also subject to inclusion in this renewal.

Nutrition services Parenting and childbirth education classes Tobacco cessation services Window replacement for lead-poisoned children

SECTION IV. COST SHARING REQUIREMENTS

Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

The cost sharing requirements requested in the Demonstration and the extension differ from those provided under the Medicaid State plan. As outlined in Attachment 3, “Cost Sharing”, the State reserves the right to set premiums to a maximum of 5% of family income. The State retains the right to adjust these premiums when it deems it appropriate and is not required to adjust premiums annually to maintain this right. The State will no longer seek to utilize co-pays in its cost sharing plan with the exception of EFP.

Indicate if there are any exemptions from the proposed cost sharing (if additional space is needed, please supplement your answer with a Word attachment).

Exemptions from cost sharing include: pregnant women, children under 1, children in foster care or adoption subsidy, post foster care coverage group (Chafee children), Alaskan Native/American Indian children and adults.

SECTION V. DELIVERY SYSTEM AND PAYMENT RATES FOR SERVICES

Question #1:

Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

- Yes** – benefits for the Medicaid population are delivered through Managed Care delivery system; managed care organizations, Primary Care Case Management Program (PCCM), or Program for all Inclusive Care for the Elderly (PACE).
- No

Question #2:

Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

In its current Demonstration Waiver, Rhode Island oversees the operation of a series of successful programs which have been nationally recognized for their quality, including RItE Care, RItE Share, Rhody Health Partners, Connect Care Choice, PACE, and Extended Family Planning. The current Demonstration Waiver has afforded the State the ability to move away from discrete, capped enrollments for home and community-based services in order to make the right services available to Medicaid enrollees at the right time and in the right setting. Going forward, Rhode Island seeks to build on its successful experience in serving Medicaid enrollees who are enrolled in its capitated managed care (RItE Care and Rhody Health Partners) and primary care case management (Connect Care Choice) programs and enhance the integration of home and community-based services into these delivery systems for persons with disabilities. Our goal is to improve quality and value by:

- Promoting members' access to a full array of health and supportive services
- Using creative strategies (such as peer navigation) to engage members in their own care and self-management in partnership with their health and social service providers
- Offering care coordination and care management services for persons with chronic medical and behavioral health needs
- Providing resources to enhance the ability of institutionalized members to be safely transitioned to home and community-based settings

Rhode Island is fully committed to monitoring the impacts of the Demonstration on quality, cost, access to care, and health status of its covered populations by using the methodologies that have been outlined in the State's *Proposed Evaluation Design for Section 1115 Waiver No. 11-W-*

00242/1, its revised *Quality Strategy for Managed Care Services*, and its quarterly *Designated Medicaid Information* report to the Rhode Island General Assembly's Senate Committee on Health and Human Services. In addition, the State's proposed Integrated Care Initiative has significant focus on quality measurement, to promote the delivery of coordinated, high quality, cost effective services for Medicare/Medicaid enrollees.

1. Patient Centered Medical Home

Furthermore, RI Medicaid has participated in a multi-payer effort to pilot and spread the Patient Centered Medical Home (PCMH) model of primary care since 2008. These efforts will continue through the period of the waiver demonstration, with the goal of an officially recognized PCMH for every RI Medicaid beneficiary. The RI PCMH efforts became rooted in legislation in July of 2011 with the passage of the Rhode Island All Payer Patient Centered Medical Home Act. This Act requires a number of payment reform and evaluation initiatives aimed at spreading the model, with leadership from the Secretary of Health and Human Services and the Office of the Health Insurance Commissioner. In 2012, Medicaid signed agreements with all of the states Federally Qualified Health Centers to become designated as Patient Centered Medical Homes. Types of PCMH payments: Through our Managed Care Organizations and PCCM programs, Medicaid will make two types of payments to the RI All Payer Patient Centered Medical Home Program:

1. PMPM care coordination payments to designated PCMHs. These payments support practices in providing on-site care management services; required data collection and quality measurement activities, expanded evening and week-end access; enhanced care transitions activities; agreements with specialty providers; co-located behavioral health care; and development of team-based care strategies and evidence based interventions for chronic disease.

2. Payments to support the all-payer program infrastructure: As required by legislation, the All-payer PCMH program is directed by a multi-stakeholder coalition which is co-convened by the Office of the Health Insurance Commissioner and the Secretary of Health and Human Services. The coalition plays a critical role in the implementation of the PCMHs and is supported by all Rhode Island insurers (including fee-for-service Medicare under the Medicare Advanced Primary Care Practice Demonstration). Payments to the coalition support the following activities:

- Data and Evaluation – definition and harmonization of quality and utilization measures to be collected and reported by the practices for payment and evaluation purposes. Development of an all-payer claims data set to track improvements in utilization of hospitals and emergency departments over time (until such time as a state-run all payer claims database is available).
- Practice transformation support – regular meetings of practices to share best practices in the transformation to a medical home, care improvements, team-based care strategies, data collection strategies, etc.
- Convening stakeholders – stakeholders meet monthly with multiple intervening sub-committee and oversight meetings. Staffing for these functions is provided by the coalition.

- Contract development – Rhode Island’s PCMH program is unique in that terms of the PCMH contract are developed publicly and all payers and practices comply with the same general contract terms.
- Collaborative measurement portal – EHR-derived quality measures are submitted to the coalition quarterly and displayed through a collaborative, web-based measurement portal. This portal allows practices to track their performance and improvement over time, to compare their performance to other PCMH’s, and for the program as a whole to track improvements in population health as a result of the PCMH intervention.

Expected benefits: The PCMH program will form the foundation of support for the Integrated Care Initiative being pursued for Medicare and Medicaid Eligibles. As that program works to provide coordinated care between the multiple elements of the health care delivery and social systems for vulnerable individuals, a highly functioning PCMH is necessary to serve as a hub of care coordination and prevention strategies. Similarly, we anticipate that the Delivery System Reform Incentive Program Pilot will need to build on a strong base of community PCMHs in order to successfully achieve the care coordination, patient experience, clinical quality and utilization goals required for the program.

2. Delivery System Reform Incentive Payment

EOHHS requests demonstration authority to pilot a “Delivery System Reform Incentive Payment” (DSRIP) program with one or more hospitals and the aligned provider community during the period of the demonstration. This effort will build on and enhance a number of other efforts being pursued in the Medicaid program, including:

- Patient centered medical homes and Health Homes for Medicaid beneficiaries
- Integrated Care Initiative for Medicare and Medicaid Eligible (MME) individuals
- Statewide Health Information Exchange (HIE)
- Multi-payer payment and delivery system reform, including payments based on quality and a transition away from a fee-for-service only payment system
- Medicaid Adult and Child core quality measurement program
- Meaningful Use and Electronic Health Record Incentive Payments
- Federally Qualified Health Center payment methodology
- Communities of Care program for high Emergency Department utilizing members
- Nursing Home Transitions and Money Follows the Person programs

Rationale:

The current system of volume-driven hospital reimbursement provides inadequate incentive for hospitals to institute delivery system reforms that would achieve the triple aim: Better Health, Better Healthcare, and Lower Costs. In particular, hospitals do not yet have adequate incentives to limit Emergency Department visits and inpatient admissions by working collaboratively with nursing homes, primary care medical homes and other outpatient providers. Payment systems based only on volume of visits and admissions do not require hospitals to establish meaningful strategies for communication and collaboration with community providers that are aimed at limiting hospital utilization and ensuring that care is delivered in the most appropriate and cost effective way. Without a change in payment methodologies, a hospital that implemented such communication and collaboration strategies could be negatively impacted by a decrease in utilization. Additionally, reimbursements to outpatient providers do not yet include adequate incentives for engaging with hospitals to limit utilization to only appropriate hospital and ED admission. Therefore, new payment strategies must be developed that reward hospitals for achieving improvements in health, healthcare and costs; and reward community providers for engaging with hospitals to achieve this goal. The RI DSRIP will test a model for addressing these misaligned incentives.

Program Description:

Under the RI DSRIP Pilot, a hospital and its affiliated community providers (the System) will be designated as eligible for incentive payments, in addition to standard payments under Medicaid Managed Care and PCCM agreements, for meeting certain targets established by the DSRIP program. The incentive strategy will be designed to eliminate the perverse incentives which inhibit the collaboration necessary to achieve the triple aim. Targets will be designed to achieve communication and integration among System providers that result in more person-centered and cost effective care. Robust quality and patient-experience measurement will be the centerpiece of the effort, to ensure that the pilot results in improvements in quality, cost and member experiences of care. The DSRIP program will require engagement by the participating providers in the quality measurement and reporting process, with oversight, monitoring and validation by the Medicaid program.

The DSRIP program will identify a population of Medicaid beneficiaries (in both the FFS and Managed care programs) receiving care from the designated System. Measures of clinical quality, utilization, and patient experience will be defined prior to program implementation and measured for this population of beneficiaries at baseline and over time. Incentive payments will be designed to reward System when benchmarks in each of the areas are met.

Building on the incentive structure designed by Oregon for their Community Care Organizations, the RI DSRIP program will be designed to affect the following critical areas of quality, patient experience, and cost:

- Reducing preventable Emergency Department visits, hospitalizations and re-hospitalizations.
- Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of

resources, including community workers, public health services, and leveraging aligned federal and state programs.

- Deploying cross-provider care teams to improve care and reduce preventable or unnecessarily-costly utilization by “super-utilizers”.
- Integrating primary care and behavioral health.
- Ensuring appropriate care is delivered in appropriate settings
- Improving perinatal and maternity care
- Improving primary care for all populations through increased adoption of the Patient-Centered Medical Home model of care

To achieve the above improvements, the System will need to rely on robust health information technology, including the state’s Health Information Exchange (currentcare), and meaningful use of interconnected and certified electronic health records.

The incentive payment structure will rely on population-based improvement in a set of clinical quality, patient experience (including access) and utilization measures. These measures will align with and build upon currently existing measurement programs, including Meaningful Use, CMS Adult and Child Core Quality Measures, Health Homes, HEDIS, and the RI Multi-payer Patient Centered Medical Home program. Measures will be drawn from the following:

- Member/patient experience of care (CAHPS tool or similar);
- Health and functional status among CCO enrollees;
- Control of and care for Diabetes, Hypertension and Coronary Artery Disease
- Rate of tobacco use among CCO enrollees;
- Obesity rate among CCO enrollees
- Outpatient and emergency department utilization;
- Potentially avoidable emergency department visits;
- Ambulatory care sensitive hospital admissions;
- Medication reconciliation post discharge;
- Timely transmission of the discharge record after hospitalization or ED visit
- Quality of care for behavioral health conditions
- All-cause readmissions;
- Alcohol misuse-screening, brief intervention, and referral for treatment;
- Initiation & engagement in alcohol and drug treatment;
- Mental health assessment for children in DCYF custody;
- Follow-up after hospitalization for mental illness;
- Effective contraceptive use among women who do not desire pregnancy;
- Low birth weight;
- Elective delivery prior to 39 weeks gestation
- Appropriate use of imaging for low back pain
- Developmental screening by 36 months; and
- Difference in these metrics between race and ethnicity categories;

Access to Care: The incentive payments must include a focus on robust access to care, particularly for behavioral health, substance abuse, and acute care on evenings and week-ends. Potential measures of access to care for the RI DSRIP include:

- Percentage of children in particular age groups with a preventive visit in prior year
- Percentage of adults with any outpatient visit.
- Percentage of adults with a chronic disease with any outpatients visit in past year
- Percentage of children with at least one dental visit.
- Change in the number of physicians (by specialty) participating in Medicaid
- Proportion of primary care provider sites recognized as Patient Centered Medical Homes
- Percentage of beneficiaries in the population with access to a PCMH
- Percent of beneficiaries with a usual source of care.
- Percent of beneficiaries with a preventive visit in the past year.
- Percent of beneficiaries delaying/deferring care due to lack of available provider.
- Percent of beneficiaries delaying/deferring care due to provider office being closed at time of illness.
- Appointment wait times for certain preventive care, such as colonoscopy, mammography and gyn services

Incentive Payment Structure:

State general revenue payments to hospitals will serve as the source of state matching funds for this initiative. Under the Affordable Care Act, the federal government will be reducing disproportionate Share Hospital Payments. EOHHS will seek General Assembly approval to invest any general revenue savings that will result in DSH decreases in SFY 2015 and beyond in the DSRIP program.

Infrastructure costs for System development will be provided to the System with DSRIP funds in Years 1-2, but must be matched by non-state funded infrastructure investments by the System. Distribution of incentive payments among System providers will be proposed by the System and approved by the State and CMS.

Timeline of Initiative:

Demonstration Year 1	<ul style="list-style-type: none"> • Identification of designated Pilot System • Identification of quality, patient experience, access, and cost measures • Baseline data collection • Development and approval by State and CMS of Incentive Structure • Agreement on Infrastructure investments and milestones for achieving infrastructure payments
Demonstration Year 2	<ul style="list-style-type: none"> • Year 1 data collection for quality, patient experience, access, and cost measures • Implementation of agreements for incentive payments among System providers • Distribution of infrastructure investments with DSRIP funds for milestones achieved
Demonstration Years 3-5	<ul style="list-style-type: none"> • Infrastructure investments completed • Quarterly monitoring of quality, patient experience, access, and cost

	measures <ul style="list-style-type: none"> • Distribution of DSRIP incentives to System for achievement of benchmarks
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3. Dental Services for Older Children and Adults

The State implemented RIte Smiles, its managed dental care benefit for Medicaid/CHIP children, in September 2006. The RIte Smiles Program currently serves Rhode Island children born on or after May 1 2000. This Program has been successful in increasing access to dental services, promoting development of good oral health behaviors, decreasing the need for emergency and restorative dental care, and decreasing Medicaid expenditures for oral health. The State requests demonstration authority to waive freedom of choice to establishing mandatory managed care enrollment for the delivery of oral health care for older children and adults, who currently receive dental care through the state’s fee for service delivery system.

4. Integrated Care Initiative

The State submitted a Category Change II Request January 2013. It is included in this extension request to highlight our focus on coordinated delivery systems. EOHHS’s Integrated Care Initiative is for persons eligible for Medicaid only or Medicaid/ Medicare benefits. The Integrated Care Initiative is founded on a care philosophy to ensure that services are delivered in the most appropriate care setting for each member based on their medical, behavioral health and social service needs.

Initially, the State will procure vendors to integrate acute, primary and specialty care with long term care services and supports. This procurement will commence in early 2013 and enrollment will begin in September. In order to achieve full integration (primary care, acute care, specialty care, behavioral health care and long-term services and supports), the State is proposing to follow two primary pathways. A summary of the pathways is described below. This approach will allow for consumer choice and ensure accountability, access and improved outcomes for Medicare and Medicaid Eligible (MME) members and those members requiring long-term care services and supports. Each of the models is not exclusive of the other and the State will pursue both major pathways in parallel.

- **Enhanced PCCM Model**

The Enhanced PCCM Model, **Connect Care Choice Community Partners (CCCCP)**, builds on the Connect Care Choice (CCC) Primary Care Case Management (PCCM) program’s demonstrated capacity and experience to serve individuals with complex medical conditions. Currently, 17 CCC practice sites, meeting standards of performance adopted from the chronic care model of “best practices” serve approximately 1,800 Medicaid-only beneficiaries across Rhode Island. The CCC model encompasses primary care/nurse case management teams and co-located behavioral health to provide quality focused and holistic care to beneficiaries. CCC 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.

To address the needs for greater integration of primary care, acute care, specialty care, behavioral health and long-term care services and for high touch care coordination, a bundled service contract will seek to build **Coordinating Care Entity (CCE)** which would oversee and manage the performance data, quality assurance and quality improvement activities and build a **Community Health Team (CHT)** that would to coordinate the social supports and services for the Medicaid-only and MME members. The CCE would coordinate the high touch care management with the existing CCC Nurse Care Managers integrated in the CCC Primary Care Practice sites and the EOHHS Office of Community Programs (OCP) Nurse Care Managers for the LTSS and CHT the to provide linkages to social supports for a coordinated, seamless delivery system. The LTSS services that are currently funded and managed through the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) will continue to be funded and managed through BHDD. The CCCCP team will coordinate these services with the BHDDH social caseworker and the BHDDH support coordinator.

- **Managed Care Organizations**

The State will contract with two or more Health Plans to provide the comprehensive array of primary care, acute care, specialty care, behavioral health, and long-term care services and supports to Medicaid-only adults who receive LTSS as well as to MME individuals who are eligible for full Medicaid benefits, under a capitation arrangement. The target populations for this enrollment fall into four groups: (1) MMEs living in the community receiving no long-term care services or supports, (2) MMEs living in the community receiving long term care services and supports, (3) MMEs living in an institutional care setting, and (4) Medicaid-only adults who receive LTSS in a nursing home or in the community.

This model will be implemented in two phases:

Phase I, effective September 1, 2013, improves the Medicaid program by enhancing the integration of the full range of services (primary care, acute care, specialty care, behavioral health care and long-term services and supports) for all Medicaid eligible adults, importantly including persons who are dually eligible for Medicaid and Medicare. Additionally, as described below, certain services for individuals with developmental disabilities and individuals with severe and persistent mental illness will not be included in Phase I.

During Phase I all MME individuals in these groups will be enrolled in a Health Plan. However, during this period services that are currently funded and managed through BHDDH will continue to be funded and managed through BHDDH. Attachment B of the Model Contract identifies those services that will remain “out-of-plan” during Phase I.

Phase II includes the provision of all Medicaid covered benefits to the Medicaid only adults who receive LTSS and to all full benefit MMEs population, except for those individuals who are specifically excluded from this initiative as described in the Model contract appended to this LOI. Phase II includes the provision of all Medicaid benefits and Medicare benefits to the Medicaid only and to dually eligible Medicaid and Medicare individuals.

Question #3:

Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- Managed care
 - Managed Care Organization (MCO)
 - Prepaid Inpatient Health Plans (PIHP)
 - Prepaid Ambulatory Health Plans (PAHP)

- Fee-for-service (including Integrated Care Models)
 - Primary Care Case Management (PCCM)
 - Health Homes

- Other (please describe)
 - PACE

Question #4:

If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option.

Eligibility Type	Delivery System
Families with Dependent Children	Enrolled in RItE Care with one of two participating MCOs for medical care. RItE Smiles PAHP for dental benefits
Women who receive Extended Family Planning Benefits	Enrolled in one of two participating MCOs
Children with Special Health Care Needs	Enrolled in RItE Care with one of two participating MCOs RItE Smiles PAHP for dental benefits

<p>Children in Substitute Care Arrangements</p> <p>Youth aged out of foster care system eligible under the Affordable Care Act</p>	<p>Enrolled in RItE Care with MCO selected by the Department of Children, Youth and Families</p> <p>RItE Smiles PAHP for dental benefits</p>
<p>Families with Dependent Children who have access to employer sponsored insurance</p>	<p>Enrolled in RItE Share program. Commercial carrier is primary, and Medicaid fee-for-service wraps around that benefit.</p>
<p>Aged, Blind, and Disabled (ABD) Adults – Medicaid Only</p>	<p>Enrolled in:</p> <ul style="list-style-type: none"> • Rhody Health Partners with one of two MCOs • Connect Care Choice • PACE • RItE Smiles PAHP
<p>Aged, Blind, Disabled (ABD) Adults – Medicare and Medicaid Eligible (MME)</p>	<p>To be Enrolled in:</p> <ul style="list-style-type: none"> • Rhody Health Options with one of two MCOs • Connect Care Choice Community Partners • PACE • RItE Smiles PAHP
<p>Childless Adults eligible under the Affordable Care Act</p>	<p>To be enrolled in RItE Care participating managed care organization and RItE Smiles PAHP</p>

SECTION VI. DEMONSTRATION FINANCING

Financing: State Funds

All non-federal share Demonstration expenditures will be financed exclusively with State general funds. The state does not intend to use a reduction in disproportionate share hospital (DSH) claims to offset demonstration costs in the calculation of budget neutrality for the demonstration.

For the renewal period, Rhode Island will finance the Demonstration as it has during the initial period. All state funds for non-federal share will continue to be derived from State general funds.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

State General Funds

- Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application)
- Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).
- Provider taxes. (Provide description the narrative section – Section VI of the application).
- Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

- Yes** – Providers receive and retain 100% of the payments for services rendered; providers receive and retain 100% of the total Medicaid expenditures claimed by the State.
- No

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

Yes

No

Providers do not participate in any intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments.

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

The NFS for each type of Medicaid payment is funded through State general fund revenues.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

The non-federal source to finance Medicaid payments comes from appropriations from the Rhode Island legislature (General Assembly). The Executive Office of Health and Human Services (EOHHS) is the single state Medicaid agencies and receives the majority of state general revenues appropriations to finance the state Medicaid program. General revenue is appropriated to other State agencies for services that are matched with federal Medicaid funding. All Medicaid financing from agencies other than the single state agency complies with 42 CFR 433.51.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

Department	Total State and Federal Expenditures SFY 2013 Enacted Budget (Appropriations)	Total State Expenditures SFY 2013 Enacted Budget (Appropriations)
EOHHS (Medicaid Agency)	\$1,618,743,395	\$797,953,120
Behavioral Healthcare, Development Disabilities and Hospitals	\$306,186,261	\$126,847,285
Department Children, Youth and Families	\$34,321,610	\$15,743,565
Department of Human Services	\$20,416,332	\$9,905,750
Department Elementary and Secondary Education	\$100,000	\$0
Department of Health	\$240,949	\$113,459
	\$1,980,008,547	\$950,563,179

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

State general revenue appropriations are directed to other state health and human service departments through the appropriations act. EOHHS as the single state Medicaid agency has interagency service agreements in place with these agencies. The agencies certify that the expenditures are eligible for FFP. The Single State Medicaid agency reviews these expenditures prior to submission on the CMS.64

There are no contributions to NFS from local government agencies (e.g. counties, local municipalities). Note that expenditures related to LEAs are not included in the Waiver.

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Source: State Budget Office database of FY 2013 Enacted for Medical Benefits Program

Name of Entity Transferring/Certifying Funds	Type of Entity (State, County, City)	Amount Transferred or Certified	Does entity have taxing authority?	Did the entity receive appropriations?	Amount of Total State and Federal Appropriations = SFY 2013
Behavioral Health, Development Disabilities and Hospitals	State	N/A	No	YES	\$306,186,261
Department Children, Youth, and Families	State	N/A	No	Yes	\$34,321,610
Department of Human Services	State	N/A	No	Yes	\$20,416,332
Department of Health	State	N/A	No	Yes	\$240,949
Elementary and Secondary Education	State	N/A	No	Yes	\$100,000

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period.

Provider Type	Outpatient Hospital UPL Payment
Non-government hospitals	7/1/2011 – 6/30/2012 : \$12,109,748 7/1/2012 – 6/30/2013 : \$11,764,752 (est.)
DSH	7/1/2012 – 6/30/2013: \$127,715,725(est.)

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

The State makes supplemental payments to hospitals based on the difference between actual Medicaid payments and an estimated outpatient upper payment limit. The methodology for determining this UPL is described in the response below.

Presented below are descriptions of the methodologies used by the State to estimate the upper payment limit for hospitals and nursing facilities.

There are two classes of hospitals in Rhode Island; State owned/operated and community non-profit hospitals. There are no privately owned or operated, or local government facilities in Rhode Island.

The one State owned hospital (Eleanor Slater Hospital) is operated and managed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). The hospital's Medicare allowable costs, as contained in the hospital's Medicare Cost Report is the basis for determining interim and final Medicaid payments. This cost-based payment methodology ensures that Medicaid payments for this class of provider do not exceed the upper payment limit.

With regard to the community non-profit hospitals, the estimated upper payment limit is based on the application of the Medicare cost to charge ratio to the hospital's Medicaid charges and comparing the result to actual Medicaid payments. Specifically, the methodology involves several steps. First, the Medicare cost to charge ratio is computed based on each hospital's most recently filed Medicare cost report. Second Medicaid costs for that period are estimated by applying the Medicare cost to charge ratio to Medicaid charges. Third, a trend factor is applied to the Medicaid cost estimates determined in step two in order to account for the difference in the hospitals' fiscal year data used in step one and the State's fiscal year Medicaid payments being compared. The resulting number represents the upper payment limit (UPL). Finally, actual Medicaid payments are compared to the estimated Medicaid costs calculated in step three. This methodology is applied in the aggregate, for both inpatient and outpatient services. The result of this analysis is that actual Medicaid payments, in the aggregate, are less than the Medicare UPL.

The State employs the following methodology to estimate upper payment limit for privately owned and/or operated nursing facilities.

Under the previous cost based payment methodology for nursing facilities, the State used a conservative methodology to determine UPL compliance. The Medicaid payments per diem rates for each facility were compared. The estimated UPL was determined by multiplying the Medicare price for the lowest Resource Utilization Group (RUG-III), PA1 per the Federal Register times the number of Medicaid days. Actual allowable Medicaid payments were then determined by 1) multiplying each facility's Medicaid per diem rate time Medicaid days, plus 2) adding in the dollar amount paid for prescription drugs for residents in nursing facilities. The estimated UPL using the lowest RUG-III value was greater than the total Medicaid dollar amount paid by the State, including payments for prescription drugs.

Effective October 1, 2012, the State implemented a new price-based payment methodology for nursing facilities using RUG-IV classifications on a patient specific basis. The State will compare the Medicare rate for each applicable RUG value, as published in the Federal Register, with each facility's price-based per diem rate for each RUG category.

Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

- Yes
 No

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

- Yes
 No

Capitation rates are certified as actuarially sound in compliance with 42 CFR 438.6(c) and the CMS Rate Setting Checklist.

Use of other Federal Funds.

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program?

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Source of Federal Funds	Amount of Federal Funds	Period of Funding
Money Follows the Person Grant	\$200,693	Actual SFY 2012

SECTION VII. BUDGET NEUTRALITY

Under the current Waiver, the state is subject to a cap on federal financing. Under this extension request, the State proposes to eliminate the federal cap and pursue budget neutrality under an alternative agreement. Total expenditures for the current Demonstration are below those projected in the “without waiver” forecasts. We look forward to working with CMS to develop an alternative arrangement that relieves the State from a federal cap but does not diminish our ability to take advantage of the additional spending authority that results from the gap between our “without waiver” and our “with waiver” expenditures.

In estimating the budget neutrality of the waiver in the proposed extension period, we must take into account the impact of the ACA. As the implementation of the ACA is on-going forecasting future enrollment, costs, and utilization for the renewal period poses unique challenges, particularly in the context of budget neutrality.

- **Timing**

The current waiver is a five year arrangement, on a calendar year basis, which began on January 1, 2009 and ends on December 31, 2013. Rhode Island proposes to renew this waiver for an additional five years as follows:

Table 7.1: Waiver Timing

Demonstration Year 6	January 1, 2014 – December 31, 2014
Demonstration Year 7	January 1, 2015 – December 31, 2015
Demonstration Year 8	January 1, 2016 – December 31, 2016
Demonstration Year 9	January 1, 2017 – December 31, 2017
Demonstration Year 10	January 1, 2018 – December 31, 2018

- **Expenditures Subject to Budget Neutrality**

Paragraph 76 of the STCs sets forth the agreement that expenditures subject to budget neutrality means all medical assistance payments except for DSH, phase down Part D contributions and LEA payments for the initial waiver period. These medical assistance payments constitute all expenditures for Demonstration Populations and Demonstration Services as described in paragraph 75 of the STCs⁴.

These Demonstration Populations and Demonstration Services for the initial waiver period are shown in Table 6.0.2. All related expenditures are reported in accordance with the CMS 64 reporting instructions.

⁴ CMMS waiver and expenditure authority, NUMBER 11W-00242/1, Rhode Island Global Consumer Choice Compact Demonstration, awarded to the Rhode Island Department of Human Services

Table 7.2: Current Expenditures Subject to Budget Neutrality

Populations	Budget Population 1	ABD no TPL
	Budget Population 2	ABD TPL
	Budget Population 3	RItE Care
	Budget Population 4	CSHCNs
	Budget Population 5	EFP
	Budget Population 6	Pregnant Expansion
	Budget Population 7	SCHIP Children
	Budget Population 8	CNOM: Substitute Care
	Budget Population 9	CNOM: CSHCNs otherwise in voluntary state custody
	Budget Population 10	CNOM: 65, <200%, at risk for LTC
	Budget Population 11	217-like, CatNeedy HCBW like svcs, Highest Need
	Budget Population 12	217-like CatNeedy HCBW like svcs, High need
	Budget Population 13	217-like Medically Needy, HCBW like svcs (high and highest). Medically Needy PACE-like participants in community
	Budget Population 14	BCCTP
	Budget Population 15	CNOM: Adults w/ disabilities at risk for LTC, <300% FPL
	Budget Population 16	CNOM: Uninsured Adults w/ mental illness
	Budget Population 17	CNOM: Youth at risk for Medicaid; at risk children < 300% FPL
	Budget Population 18	HIV
	Budget Population 19	CNOM: Non-working disabled adults 19-64, GPA
Services	Budget Services 1	Windows
	Budget Services 2	RItE Share and collections
	Budget Service 3	Other payments - e.g.FQHC suppl., stop loss

Budget Services 4	CNOM: core and preventive svcs, Medicaid eligible at risk youth
Budget Services 5	CNOM: Services by FQHCs to uninsured individuals

- **Adults without Dependent Children**

It is anticipated that Rhode Island will extend coverage to adults without dependent children pursuant to provisions of ACA. This action is subject to State legislation extending coverage to this group.

- **Changes in CNOMs**

Some changes in CNOMs are currently under consideration in Rhode Island.

- **Extension of Health Home Enhanced FMAP**

In November 2011, Rhode Island received approval from CMS for two Health Home State Plan Amendments. Community Mental Health Organizations serving clients with Severe and Persistent Mental Illness (SPMI) are one such designated Health Home, and the other is CEDARR Family Centers (CFCs).

Under the Affordable Care Act Section 2703, enhanced FMAP was available for 8 calendar quarters for Health Home services. EOHHS is requesting an extension of the enhanced FMAP for 8 additional calendar quarters for both approved Health Homes.

These potential changes to populations and services (and others) may be incorporated into the state's forecasted expenditures in future drafts as additional data, analysis and projections become available and policy recommendations are finalized.

Step 1: Developing the Without Waiver (WOW) Forecast

Table 7.3: Budget Neutrality To Date (Initial Waiver Period)

	DY 1 CY 2009	DY 2 CY 2010	DY 3 CY 2011	DY 4 CY 2012 (thru 9/30/2012)
Cumulative Target (\$ Million)	\$2,600	\$5,000	\$7,300	\$9,100
Annual Target (\$ Million)	\$2,600	\$2,400	\$2,300	\$1,800
Cum Actual Expenditures	\$1,762	\$3,656	\$5,518	\$6,794
Annual Actual Expenditures	\$1,762	\$1,894	\$1,862	\$1,277
Cumulative Surplus	\$838	\$1,344	\$1,782	\$2,306
Annual Surplus	\$838	\$506	\$438	\$523

DY 4 includes 1/1/2012 – 9/30/2012. For further detail see RI EOHHS website for “Quarterly Operation Report Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration July 1, 2012 – September 30, 2012”

Rhode Island anticipates that the budget neutrality targets above shall be carried forward into the renewal period and budget neutrality calculations will be cumulative over the life of the waiver. Annual without waiver expenditure targets for the Demonstration Years in the renewal period will be based on year five of the initial period trended forward.

Step 2: Develop a baseline With Waiver (WW) Forecast

Once a without waiver target is established, budget neutrality requires that the state develop an anticipated “with waiver” baseline forecast.

To project expenditures, Rhode Island is in the process of examining historical enrollment and expenditure experience, and using that experience to develop a baseline projection of Rhode Island Medicaid enrollment and expenditures, under the waiver extension.

Key considerations in this analysis include:

- Capturing and analyzing data by subgroups. Rhode Island is currently considering three subgroups: (1) ABD adults (21-64) (2) ABD Adults (65+); and (3) All Children and Families. These sub-groupings may be refined over the coming months.
- Adjusting experience to reflect the prescription drug expenditures that were assumed by the Federal government as part of the Medicare Part D program. That is, expenditures made for Medicare covered prescriptions for dually-eligible individuals are removed from all years. This provides a more accurate basis for identifying historical trends applicable to the current program and for forecasting trends during the waiver period.
- Establishing a bridge period to estimate experience between the most recent historical year and the last day of the year immediately preceding the first Demonstration Year.
- Developing adjustments for historical data anomalies. This may include items such as enrollment/cost trend anomalies due to one-time policy changes, adjustments data/anomaly year costs, etc. An example of this is the ACA provision regarding Medicaid rebates for pharmacy within managed care. This is a one-time event that impacts historical trend experience but will not similarly impact trend in future periods.
- Comparing historical claims reporting to CMS-64 reports, considering differences in timing, completion factors and payment dates. Historical claims reporting is generally performed on an incurred (date of service), not a paid basis, adjusted for completion.

Step 3: Adjustments to the Baseline Forecasts

Once the baseline forecasts are developed (with and without a waiver), these baseline projections must be adjusted for known and unknown future policy and environmental factors, anticipated during the bridge or renewal period. The state anticipates, and is currently analyzing four major adjustments to the baseline projections.

- **Adjustment Category 1: Future Policy and Eligibility Adjustments**

Rhode Island is currently considering some changes to populations and services

provided under the waiver, such as CNOMS, income limits for parents, other changes to eligibility. These potential changes to populations and services (and others as they are identified) will be incorporated into the state's forecasted expenditures as additional data, analysis and projections become available and policy recommendations are finalized.

- **Adjustment Category 2: Future Environmental Factors**

These adjustment include items such as anticipated population shifts/aging populations, economic downturn/rising unemployment, and other relevant environmental factors.

- **Adjustment Category 3: ACA related adjustments to existing populations and services**

The newly adjusted baseline must then be adjusted for changes related to the ACA. The Affordable Care Act sets the stage for major system reform and program improvement. Many changes will simultaneously be set in motion and it is simply not possible to accurately predict how these multiple factors will together play out. Some examples of the ACA related adjustments currently under development include:

- **Individual Mandate, Exchange Implementation**

Under the ACA, beginning in 2014, most Rhode Islanders must purchase health insurance, or face a tax based penalty. At this same time, Rhode Island's health benefits exchange will open its doors, offering advanced payment tax credits to individuals and families between 133 and 400% FPL. These changes are likely to have an impact on the take up of insurance within the Medicaid eligible population. As such, Rhode Island is carefully modeling the anticipated impact of these changes on the likely enrollment in existing programs, post 2014.

- **Employer Mandate, Exchange Implementation**

Under the ACA, beginning in 2014, many employers must offer health insurance to their employees, or face a tax-based penalty. At the same time, Rhode Island's health benefits exchange will open its doors, offering advanced payment tax credits to individuals and families between 133 and 400% FPL. Employer responses to these fundamental changes in health coverage options could have a substantial impact on the take up of insurance within the Medicaid eligible population. And given the states' fiscal reliance on the Rite Share program, these changes could also increase program costs.

- **Primary Care Spending Increase ("PCP Bump")**

The ACA requires that Medicaid payment rates for some categories of primary care spending increase to equal Medicare rates for a two year period. Adjustments are currently under development considering the impact on Medicaid payment rates, utilization rates, and average unit costs as a result of this initiative. To the degree that implementation of the PCP bump affects provider participation in Medicaid, it will also impact market share for the affected group of providers and future trends.

- **Adjustment Category 4: Incorporate new populations: Adults without children**

Once a with waiver baseline projection is developed, the projection must then incorporate new populations. It is anticipated that Rhode Island will extend coverage to adults

without dependent children pursuant to provisions of ACA. This action is subject to State legislation extending coverage to this group.

As such, estimated enrollment and cost projections for adults without children are under development.

SECTION VIII. CURRENT AND PROPOSED WAIVERS AND EXPENDITURE AUTHORITIES

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Rhode Island for items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration, be regarded as expenditures under the State's title XIX plan.

The following expenditure authority shall enable Rhode Island to operate its section 1115 Medicaid Global Consumer Choice Compact.

1. Expenditures for medical assistance to individuals who meet the non-financial qualifications for eligibility groups included in the approved State plan as of November 1, 2008, are not eligible under such plan, but who are eligible under the methods and standards for determining income under the demonstration.
2. Budget Population 3: Expenditures for medical assistance for children through age 18 whose family income is equal to or less than 250 percent of the Federal Poverty Level (FPL) and who are not otherwise eligible under the approved Medicaid State Plan.
3. Budget Population 5 [EFP]:
 - a. Expenditures for family planning services under the Extended Family Planning program, for women of childbearing age whose family income is at or below 200 percent of the FPL who lose Medicaid eligibility at the conclusion of their 60-day postpartum period and do not have access to creditable health insurance. Continued program eligibility for these women will be determined by the twelfth month after their enrollment in the program.
 - b. Expenditures for family planning services for enrollees in the Extended Family Planning program with incomes between 200 and 250 percent of the FPL that are furnished from January 1, 2009 through the date upon which their eligibility for the program is determined using the new net income criteria of 200 percent of the FPL.

Budget Population 6a [Pregnant Expansion]: Expenditures for medical assistance for pregnant women with incomes from 186 percent to 250 percent of the FPL who are not otherwise eligible under the Medicaid State Plan.

Budget Population 6b [Pregnant Expansion]: Individuals who, at the time of initial application: (a) are pregnant women; (b) have TPL or other coverage; (c) have net family incomes between 185 and 250 percent of the FPL; (d) receive benefits only by virtue of the Global Consumer Choice demonstration; and (e) meet the citizenship and identity requirements specified in the Deficit Reduction Act of 2005.

4. Expenditures for medical assistance furnished to individuals who are receiving home and community based services, are not otherwise eligible under the approved State Plan, whom

are found to be in the highest and high need group, and whose income and resources are within the level to qualify for eligibility under the standard for institutionalized individuals.

5. Expenditures for medical assistance for the following populations:

- a. **Budget Population 8** [*substitute care*]: Children and families in managed care (children under 19 & parents). Parents pursuing behavioral health treatment with children temporarily in State custody with income up to 200 percent of the FPL.
- b. **Budget Population 9** [*Children with special health care needs Alt.*]: CSHCN (as an eligibility factor) who are 21 and under who would otherwise be placed in voluntary State custody up to 300 percent of the SSI.
- c. **Budget Population 10** [Elders 65 and over]: At risk for LTC with income at or below 200 percent of the FPL who are in need of home and community-based services (state only group).
- d. **Budget Population 11**: 217-like Categorically Needy Individuals receiving HCBW-like services & PACE-like participants highest need group.
- e. **Budget Population 12**: 217-Like Categorically needy individuals receiving HCBW like services and PACE like participants in the High need group
- f. **Budget Population 13**: 217 Like Medically needy receiving HCBW like services in the community (high and highest group). Medically needy PACE-like participants in the community
- g. **Budget Population 14**: [BCCTP] Women screened for breast or cervical cancer under CDC program and not eligible for Medicaid.
- h. **Budget Population 15** [**Adults with disabilities at risk for long-term care**]: HCBS waiver like services for adults living with disabilities with incomes at or below 300 percent of the SSI with income and resource lists above the Medicaid limits.
- i. **Budget Population 16** [**Uninsured adults with mental illness**]: Services for uninsured adults with mental illness and or substance abuse problems with incomes below 200 percent of the FPL not eligible for Medicaid.
- j. **Budget Population 17** [**Youth at risk for Medicaid**]: Coverage of detection and intervention services for at risk young children not eligible for Medicaid up to 300 percent of the SSI.
- k. **Budget Population 18** [**HIV**]: Persons living with HIV with incomes below 200

percent of the FPL who are ineligible for Medicaid.

I. Budget Population 19 [Non-working disabled adults]: Non-working disabled adults ages 19-64 who do not qualify for disability benefits.

6. RItE Share [Budget Services 2]: Expenditures for part or all of the cost of private insurance premiums and cost sharing for eligible individuals which are determined to be cost-effective using State-developed tests that may differ from otherwise applicable tests for cost-effectiveness.
7. Window Replacement [Budget Services 1]: Expenditures for window replacement for homes which are the primary residence of eligible children who are lead poisoned.
8. Demonstration Benefits: Expenditures for benefits specified in Attachment A and A1 of the STCs provided to Demonstration populations, which are not otherwise available in the Medicaid State Plan.
9. Expenditures for Healthy Choice Accounts and Healthy Choice incentives.
10. Expenditures for the provision of HCBS waiver-like services that are not otherwise available under the approved State plan, net of beneficiary post-eligibility responsibility for the cost of care.
11. Expenditures for core and preventive services for Medicaid eligible at risk youth (Budget Services 4).
12. Expenditures not to exceed on an annual basis \$2.4 million total computable (federal and non-federal) for payments to Federally Qualified Health Centers (FQHCs) for uninsured populations. (Budget Services 5)

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to Budget Population 5.

Title XIX Requirements Not Applicable to Budget Population 5:

Amount, Duration, and Scope

Section 1902(a) (10) (B)

To enable Rhode Island to provide a benefit package consisting only of approved family planning services

CHIP Expenditure Authority

1. Expenditures for medical assistance for children through age 18 whose family income is

equal to or less than 250 percent of the Federal Poverty Level (FPL) and who are not otherwise eligible under the approved Medicaid State Plan.

Title XIX Waivers

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the Demonstration project. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Rhode Island to carry out the Rhode Island Global Compact section 1115 Demonstration.

1. Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To enable Rhode Island to vary the amount, duration and scope of services offered to individuals, regardless of eligibility category, by providing additional services to individuals for enrollees in certain managed care arrangements.

2. Reasonable Promptness **Section 1902(a)(8)**

To enable the State to impose waiting periods for HCBS waiver-like long term care services.

3. Cost-Sharing Requirements **Section 1902(a)(14) insofar as it incorporates Section 1916**

To permit the State to impose premiums in excess of statutory limits under section 1916.

4. Comparability of Eligibility Standards **Section 1902(a)(17)**

To permit the State to apply different standards for determining eligibility, including but not limited to different income counting methods, than specified in the Medicaid State plan.

5. Freedom of Choice **Section 1902(a)(23)**

To enable the State to restrict freedom of choice of provider for individuals in the demonstration.

6. Retroactive Eligibility **Section 1902(a)(34)**

To enable the State to exclude individuals in the demonstration from receiving coverage for up to three months prior to the date that an application for assistance is made.

The waiver of retroactive eligibility does not apply to individuals under section 1902(l)(4)(A).

7. Payment for Self-Directed Care

Section 1902(a) (32)

To permit individuals to self-direct expenditures for long-term care services.

8. Payment Review

Section 1902(a)(37)(B)

To the extent that prepayment review may not be available for disbursements under a self-directed care program by individual beneficiaries to their providers.

SECTION IX. PUBLIC NOTICE

In accordance with the notice requirements set forth in 42 CFR 431.408, Rhode Island initiated a public comment period for its 1115 waiver extension request. The state provided a thirty-day public notice and review period, beginning on January 18, 2013 and ending on February 18, 2013. Public notice of the application was published in the *Providence Journal*, the daily newspaper with the widest circulation in the state. The application, descriptions of the public notice process, public input on the waiver, and the public hearing schedule were also posted on the state's website.

The state held two public hearings in separate parts of the state:

Public hearing #1:

January 28, 2013 from 1:00 to 3:00 pm at the Waiver Task Force Meeting held at The Arnold Conference Center, Cranston, RI

Public hearing #2:

February 8, 2013 from 4:00 to 6:00 pm held at the Department of Health Auditorium, Providence, RI.

The public was able to participate by conference call during the February 8, 2013 session.

The state used an electronic mailing list to notify the public of any events or changes related to the application. Any member of the public could sign up to receive email by requesting so on the website.

All comments received during the 30-day comment period and a summary of the state's responses were posted on the website. The comments and responses are also attached as an appendix.

In compliance with federal directives regarding "consultation and coordination with Indian and Tribal governments," the state contacted the Narragansett Tribe on January 11, 2013. The Narragansett Tribe is Rhode Island's only federally recognized Indian Tribe. The state announced its intention to submit the waiver application by certified letter. This letter and the tribe's response are attached as an appendix.

SECTION X. DEMONSTRATION ADMINISTRATION

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Medicaid Director
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ATTACHMENT 1: 1115 Waiver - Category Changes			
Number	Date Submitted	Effective Date	Title
2013			
13-01-CII	N/A		Integrated Care Initiative
2012			
12-01-CII	2/23/12	4/1/12	Pain Management
12-02-CII	3/29/12 6/5/12	4/1/12	Nursing Facility Rate Reduction
12-03-CII	5/21/12	7/1/12	Modify the rate paid for Durable Medical Equipment Services
12-04-CII	5/16/12 8/24/12	7/1/12	Nutrition Benefits to RHP
12-05-CII	N/A	N/A	Draft not officially submitted
12-06-CII	12/7/12	7/1/13	License Fee Waiver
12-07-CII	12/28/12	10/1/12	Nursing Home Payment
2011			
11-01-CII	6/4/11	12/20/11	HCBS for Individuals with DD
11-02-CI	8/22/11	10/1/11	Elimination of Rlte Share Provider CoPayments
11-03-CI	8/22/11	10/1/11	Rlte Care/Rlte Share Co-Share Premiums to 5% of Family Income
11-04-CII	9/30/11	10/1/11	Elimination of Nursing Home Facility Rate Adjustment
2010			
10-01-CII	2/15/10	4/1/10	Reimbursement Methodology for Inpatient Hospital Services
10-03-CI	12/17/10	1/1/10	Medicare Improvements for Patients and Providers Act of 2008
10-04-CI	12/17/10	1/1/10	Tribal Consultation
10-05-CI	12/17/10	1/1/10	PARIS Data Match
10-06-CI	12/17/10	1/1/11	Screening, Brief Intervention, Referral and Treatment
2009			
09-01-CII	6/8/09	7/22/09	
09-02-CI	6/8/09		Prescription Drugs CMAP under Medicaid Drug Rebate Prog.
09-03-CII			WITHDRAWN
09-04-CII	8/13/09	10/1/09	Outpatient Hospital Services

CATEGORY CHANGES

The initial waiver period began in January, 2009. Pursuant to the program flexibility provisions of the waiver, several category changes have been submitted to CMS. The table above provides a list of Category Changes, approved and under review. Rhode Island intends that each of these be incorporated into and carried forward into the renewal period.

ATTACHMENT 2 – Core and Preventive Home and Community-based Service Definitions

Homemaker: Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

Environmental Modifications (Home Accessibility Adaptations): Those physical adaptations to the private residence and/or vehicle of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheel chair). All services shall be provided in accordance with applicable State or local building codes and are prior approved on an individual basis by the EOHHS Office of Long Term Services and Supports.

Special Medical Equipment (Minor Assistive Devices): Specialized Medical Equipment and supplies including: (a) devices, controls, or appliances specified in the plan of care, which enable a participant to increase his/her ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which he/she lives, including such other durable and non-durable medical equipment that is necessary to address participant functional limitations and that is not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Provision of Specialized Medical Equipment requires prior approval on an individual basis by the EOHHS, Office of Long Term Services and Supports.

Meals on Wheels (Home Delivered Meals): The delivery of hot meals and shelf staples to the waiver recipient's residence. Meals are available to an individual who is unable to care for his/her nutritional needs because of a functional dependency/disability and who requires this assistance to live in the community. Meals provided under this service will not constitute a full daily nutritional requirement. Meals must provide a minimum of one-third of the current recommended dietary allowance. Provision of home delivered meals will result in less assistance being authorized for meal preparation for individual participants, if applicable.

Personal Emergency Response (PERS): PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual

may also wear a portable "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center, as specified by Center for Adult Health contract standards. This service includes coverage for installation and a monthly service fee. Providers are responsible to insure the upkeep and maintenance of the devices/systems.

LPN Services (Skilled Nursing): Licensed Practical Nurse services provided under the supervision of a Registered Nurse. Licensed Practical Nurse Services are available to participants who require interventions beyond the scope of Certified Nursing Assistant (C.N.A.) duties. LPN services are provided in accordance with the Nurse Practice Act under the supervision of a registered nurse. This service is aimed at individuals who have achieved a measure of medical stability despite the need for chronic care nursing interventions.

Community Transition Services: Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the individual is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable an individual to establish a basic household; these expenses do not constitute room and board and may include: security deposits that are required to obtain a lease on an apartment or home, essential household furnishings, and moving expense, set-up fees or deposits for utility or service access, services necessary for the individual's health and safety and activities to assess need, arrange for, and procure needed resources. Community Transition Services are furnished only to the extent that the services are reasonable and necessary as determined through the service plan development process, the services are clearly identified in the service plan, and the individual is unable to meet such expense or the services cannot be obtained from other sources. The services do not include ongoing shelter expenses, food, regular utility charges, household appliances or items intended for recreational purposes.

Residential Supports: Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in his/her own home and a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance (where applicable), or upkeep and improvement.

Day Supports: Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day supports focus on enabling the individual to attain or maintain his/her maximum functioning level, and are coordinated with any other services identified in the person's individual plan.

Supported Employment: Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by an individual receiving waiver services as a result of his/her disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Living Arrangements: Personal care and services, homemaker, chore, attendant care, companion services, and medication oversight (to the extent permitted under State law) provided in a private home by a principal care provider who lives in the home. Supported Living Arrangements are furnished to adults who receive these services in conjunction with residing in the home. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Supported Living Arrangements, since these services are integral to and inherent in the provision of adult foster care services.

Private Duty Nursing: Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law and as identified in the Individual Service Plan (ISP). These services are provided to an individual at home.

Supports for Consumer Direction (Supports Facilitation): Focuses on empowering participants to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the participant through the service planning and delivery process. The Facilitator counsels, facilitates, and assists in development of an ISP which includes both paid and unpaid services and supports designed to allow the participant to live in the home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the Individual Service Plan are temporarily unavailable.

Participant Directed Goods and Services: Participant Directed Goods and Services are services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need, that are in the approved ISP (including improving and maintaining the individual's opportunities for full membership in the community), and that meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR the item or service would promote inclusion in the community; AND/OR the item or service would increase the individual's ability to perform ADLs or IADLs; AND/OR the item or service would increase the person's safety in the home environment; AND alternative funding sources are not available. Individual Goods and Services are purchased from the individual's self-directed budget through the fiscal intermediary when approved as part of the ISP. Examples include a laundry service for a person unable to launder and fold clothes, or a microwave for a person unable to use a stove due to his/her disability. This will not include any good/service that would be restrictive to the individual or strictly experimental in nature.

Case Management: Services that assist participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case managers are responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and review of plans of care on an annual basis and when there are significant changes in client circumstances.

Senior Companion (Adult Companion Services): Non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise the

participant with such tasks as meal preparation, laundry, and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan of care.

Assisted Living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility; but the care provided by these other entities supplements that provided by the community care facility and does not supplant it. Personalized care is furnished to an individual who resides in his/her own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms, and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other unit. The facility must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living room or dining room). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and must treat each person with dignity and respect. Costs of room and board are excluded from payments for assisted living services.

Personal Care Assistance Services: Personal Care Assistance Services provide direct support in the home or community to an individual in performing tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided by a Certified Nursing Assistant and meet such standards of education and training as are established by the State for the provision of these activities or via Employer Authority under Self Direction options. Personal Care Services may provide:

- Assistance with activities of daily living, such as grooming, personal hygiene, toileting, bathing, and dressing
- Assistance with monitoring health status and physical condition
- Assistance with preparation and eating of meals (not the cost of the meals itself)
- Assistance with housekeeping activities (bed making, dusting, vacuuming, laundry, grocery shopping, cleaning)
- Assistance with transferring, ambulation, and use of special mobility devices

- Assisting the participant by directly providing or arranging transportation. (If providing transportation, the PCA must have a valid driver's license and liability coverage as verified by the FI)

Respite: Respite can be defined as a service provided to a participant unable to care for himself/herself that is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Allocation of Respite hours will be recommended and approved by EOHHS, Office of Long Term Services and Supports

Preventive Services: Homemaker: Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him/herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

Minor Environmental Modifications: Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances, such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers), and standing poles to improve home accessibility adaption, health, or safety.

Physical Therapy Evaluation and Services: Physical therapy evaluation for home accessibility appliances or devices by an individual with a State-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.

ATTACHMENT 3: COST SHARING CHART

The following premiums and co-payments limits apply to the populations as noted below. This chart reflects the structure of the waiver extension only.

	Children Under 1*	Children 1 to 19 th birthday*	Adults	Pregnant Women	Extended Family Planning	
Family Income	Premiums	Premiums	Premiums	Premiums	Premiums	Copays
Under 100% FPL	None	None	None	None	None	\$2 health care provider visits \$1 for 30 day supply of contraceptives \$15 voluntary sterilization procedures
100-133% FPL	None	None	None	None	None	\$2 health care provider visits \$1 for 30 day supply of contraceptives \$15 voluntary sterilization procedures
133-150% FPL	None	up to 5% of family income	up to 5% of family income	None	None	\$2 health care provider visits \$1 for 30 day supply of contraceptives \$15 voluntary sterilization procedures

150-185% FPL (150-175% FPL for adults)	None	up to 5% of family income	up to 5% of family income	None	None	\$2 health care provider visits \$1 for 30 day supply of contraceptives \$15 voluntary sterilization procedures
185-250% FPL	up to 5% of family income	up to 5% of family income	N/A	up to 5% of family income	None	\$2 health care provider visits \$1 for 30 day supply of contraceptives \$15 voluntary sterilization procedures
<p>Cost Sharing exemptions:</p> <ul style="list-style-type: none"> - children in foster care or adoption subsidy - Post foster care coverage group (Chafee children) -Alaskan Native/American Indian children and adults 						

- Cost-sharing for BBA working disabled adults defined in section 1902(a)(10)(A)(ii)(XIII) will follow the Medicaid State Plan
- All unearned income over the Medically Needy Income Limit (MNIL) will be owed as a monthly premium;
- Cost-Sharing for [Elders 65 and over] At risk for LTC with income at or below 200 percent of the FPL who are in need of home and community-based services (state only group) is to be treated like post-eligibility treatment of income or spend down requirements.

ATTACHMENT 4: EVALUATION STATUS AND FINDINGS FOR THE 1115 WAIVER

Executive Office of Health and Human Services (EOHHS)

State of Rhode Island and Providence Plantations

January 2013

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CHAPTER I

BACKGROUND ON THE DEMONSTRATION PROJECT

On January 16, 2009, the State of Rhode Island was granted a Section 1115 waiver (11-W-00242/1) for the Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration. This Demonstration is a direct consequence of the Rhode Island Medicaid Reform Act of 2008, which directed the State to apply for a “global” demonstration under the authority of Section 1115(a) of Title XI of the Social Security Act. Section 42-12.4-2 of the General Laws of Rhode Island (R.I.G.L.) delineated the following legislative intent:

“§ 42-12.4-2 Legislative intent. – (a) It is the intent of the general assembly that Medicaid shall be a sustainable, cost-effective, person-centered and opportunity-driven program utilizing competitive and value-based purchasing to maximize available service options; and

(b) It is the intent of the general assembly to fundamentally redesign the Medicaid Program in order to achieve a person-centered and opportunity-driven program; and

(c) It is the intent of the general assembly that the Medical Assistance Program be a results oriented system of coordinated care that focuses on independence and choice that maximizes the available service options, promotes accountability and transparency; encourages and rewards healthy outcomes and responsible choices; and promotes efficiencies through interdepartmental cooperation.

(d) The executive office of health and human services and the department of human services are authorized and shall apply for and obtain a global waiver and/or any necessary waivers and/or state plan amendments from the secretary of the United States Department of Health and Human Services, including, but not limited to, a waiver of the appropriate sections of Title XIX, 42 U.S.C. § 1396 et. seq. The application for and the provisions of such waiver(s) and/or state plan amendments shall be implemented as follows:

(1) The federal waiver application process shall be overseen by the respective finance committees of both chambers of the general assembly. Ten (10) days prior to submission to the federal government, the executive office of health and human services and the department of human services will provide the general assembly with the proposed submission data related to the federal global waiver application required by the federal Center for Medicare and Medicaid services;

(2) Prior to the final acceptance of the federal global waiver by the state, the executive office of health and human services and the department of human services shall allow the respective finance committees of both chambers of the general assembly to review all materials related to the federal global waiver, including the materials submitted by the state and the tentative approval letter; moreover, the executive office of health and human

services and the department of human services may accept the federal global waiver if the general assembly does not repeal the authority to pursue the global waiver within thirty (30) days of the receipt of the proposed federal waiver;

(3) Upon the enactment of legislation related to the federal waiver(s), the executive office of health and human services and the health and human services agencies, as defined in § 42-7.2-2, are authorized and directed to adopt rules and regulations in order to implement the provisions of the federal waiver(s) and/or state plan amendments.”

However, as R.I.G.L. Section 42-12.4-3 makes clear, many of the details of the Demonstration will evolve as specific statutory changes are approved:

“§ 42-12.4-3 Legislative enactments. – Until statutory changes are enacted through the legislative process, all applicable laws remain in effect. It may be necessary to propose legislative changes in order to comply with the federal waiver(s). In order to effectuate additional programmatic changes to the Medicaid program beyond those authorized in the 2008 legislative session, and as authorized by the federal waiver, the executive office of health and human services and the department of human services shall propose additional appropriate legislative amendments. Such additional legislative changes cannot be effectuated until the necessary statutory enactments have been passed.”

Federal approval of the specific changes is also be required.

1. Overview of the Demonstration

Below is a brief overview of the Demonstration.

1.1 Demonstration Project Timelines

Important demonstration project dates include:

- Initial Waiver Application Submitted: August 8, 2008
- Initial Waiver Application Approved: January 16, 2009
- Demonstration Project Implemented: July 1, 2009
- Demonstration Expiration Date: December 31, 2013

1.2 Demonstration Description

Rhode Island's Global Consumer Choice Compact Demonstration (the Demonstration) establishes a new Federal-State compact that provides the State with substantially greater flexibility than is available under existing program guidelines. The State will use the additional flexibility afforded by the Demonstration to redesign the State's Medicaid program to provide cost-effective services that will ensure beneficiaries receive the appropriate services in the least restrictive and most appropriate setting. In exchange for the increased flexibility and the opportunity to invest in Medicaid reform, the State will operate the Medicaid program during the Demonstration under a mutually agreed upon five-year aggregate cap of Federal funds, thereby assuming a degree of financial risk with respect to caseload and per member per month cost trends.

Accordingly, Rhode Island is operating its entire Medicaid program under a single Section 1115 demonstration project with the exception of disproportionate share hospital (DSH) payments and payments to local education agencies (LEAs).⁵ All Medicaid-funded services on the continuum of care – from preventive care in the home and community to care in high-intensity hospital settings to long-term and end-of life-care – will be organized, financed, and delivered through the Demonstration. Rhode Island's Section 1115 RItE Care and RItE Share programs for children and families, the 1915(b) Dental Waiver (RItE Smiles), and the Section 1915(c) Home and Community Based Services waivers have been included in the Global Consumer Choice Compact Demonstration.

According to the Special Terms and Conditions (STCs) of the Demonstration, the State has flexibility to make changes to the Demonstration based on how the changes align with the following categories in Paragraph 17 of the STCs:

- a) **Category I Change:** Is a change which is administrative in nature for which the State has current authority under the State plan or demonstration, and which does not affect beneficiary eligibility, benefits, overall healthcare delivery systems, payment methodologies or cost sharing. The State must notify CMS of such changes either in writing or orally in the periodic review calls and update reports as specified in the General Reporting Section paragraphs 71 through 73. Implementation of these changes does not require approval by CMS.

Examples of Category I changes include, but are not limited to:

- Changes to the instruments used to determine the level of care
- Changes to the Assessment and Coordination Organization Structure
- Changes to general operating procedures
- Changes to provider network methodologies (provider enrollment procedures, but not delivery system changes)
- Changes to prior authorization procedures
- Adding any HCBS service that has a core definition in the 1915(c) Instructions/Technical Guidance if the State intends to use the core definition.
- Modifying an HCBS service definition to adopt the core definition.

⁵ Administrative expenses and phased-Medicare Part D contributions are also excluded from the five-year aggregate cap on Federal funds.

- b) **Category II Change:** Is a change that could be made as a State Plan Amendment or through authority in sections 1915(b), 1915(c), 1915(i) or 1915(j) without any change in either the STCs, or the section 1115 waiver and expenditure authorities. These changes may affect benefit packages, overall healthcare delivery systems, cost sharing levels, and post-eligibility contributions to the cost of care. Such changes do not, however, include changes that affect beneficiary eligibility (including changes to the level of spenddown eligibility). The State must comply with its existing public notice process prior to implementation, and must comply with the section 1115 demonstration public notice process as described in paragraph 14 of these STCs. The State must notify CMS in writing of Category II changes, and must furnish CMS with appropriate assurances and justification, that include but are not limited to the following:
- i) That the change is consistent with the protections to health and welfare as appropriate to title XIX of the Act, including justification;
 - ii) That the change results in appropriate efficient and effective operation of the program, including justification and response to funding questions;
 - iii) That the changes would be permissible as a State Plan or section 1915 waiver amendment; and that the change is otherwise consistent with sections 1902, 1903, 1905, and 1906, current Federal regulations, and CMS policy interpretive issuances; and
 - iv) Assessment of the cost of the change.

The State must not implement these changes until CMS approves these assurances. CMS will not provide Federal matching funds for activities affected by unapproved but implemented Category II changes.

Examples of Category II changes include, but are not limited to:

- Changes to the ICF/MR, hospital or nursing home level of care criteria that are applied prospectively (not to existing long term care or HCBS recipients);
- Adding any HCBS service for which the State intends to use a definition other than the core definition. (The service definition must be included with the assurances.)
- Modifying any HCBS service definition unless it is to adopt the core definition.
- Adding an “other” HCBS service that does not have a core definition. (The service definition must be included with the assurances.)
- Removing any HCBS service that is at that time being used by any participants.
- Change/modify or end RItE Share premium assistance options for otherwise eligible individuals;
- Changes to payment methodologies for Medicaid covered services including, but not limited to DRG payments to hospitals or acuity based payments to nursing homes;
- Healthy Choice Accounts Initiatives;
- Addition or elimination of optional State plan benefits;

- Changes in the amount, duration and scope of State plan benefits that do not affect the overall sufficiency of the benefits;
 - Benefit changes up to the DRA Benchmark flexibility limits; and
 - Cost-Sharing Cchanges up to the DRA limits unless otherwise defined in the STCs or currently waived.
- c) **Category III Change:** Is a change requiring modifications to the current waiver or expenditure authorities including descriptive language within those authorities and the STCs, and any other change that is not clearly described within Categories I and II. In addition, a programmatic change may be categorized as a Category III change by the State to obtain reconsideration after unsuccessfully pursuing approval of the change under Category II. The State must comply with the section 1115 demonstration public notice process as described in paragraph 14 of these STCs. The State must notify CMS in writing of Category III changes, and submit an amendment to the demonstration as described in paragraph 18: “Process for Changes to the Demonstration”. Category III changes shall not be implemented until after approval of the amendment by CMS.

Examples of Category III changes:

- All Eligibility Changes
- Changes in EPSDT
- Spend-down level changes
- Aggregate cost-sharing changes that are not consistent with DRA cost sharing flexibility (would exceed 5 percent of family income unless, otherwise specified in these STCs);
- Benefit changes that exceed DRA benchmark flexibility;
- Post-eligibility treatment of income; and
- Amendments requesting changes to the budget neutrality cap.”

The STCs provide expedited processes and timeframes for accomplishing the above three types of Category changes.

CHAPTER II

GOALS AND OBJECTIVES OF THE DEMONSTRATION

Rhode Island's Global Waiver was approved by the Centers for Medicare and Medicaid Services on January 16th, 2009, under the authority of Section 1115(a)(1) of the Social Security Act. The State sought and received Federal authority to promote the following goals:

- To rebalance the publicly-funded long-term care system in order to increase access to home and community-based services and supports and to decrease reliance on inappropriate institutional stays
- To ensure that all Medicaid beneficiaries have access to a medical home
- To implement payment and purchasing strategies that align with the Waiver's programmatic goals and ensure a sustainable, cost-effective program
- To ensure that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice
- To maximize available service options
- To promote accountability and transparency
- To encourage and reward health outcomes
- To advance efficiencies through interdepartmental cooperation

In Rhode Island's proposed Evaluation Design, which was submitted to the Centers for Medicare and Medicaid Services on 07/17/2009, a set of goals, objectives, and evaluation questions were proposed to address the five (5) major components of the State's Global Consumer Choice: Long-term care; RIte Care; RIte Share; Extended Family Planning; and Expansion (Costs Not Otherwise Matchable/CNOM) Groups.

For each of the major areas, the goals and objectives for the Demonstration are as follows:

- **Long-term Care Goal 1:** To undertake measurable reform of Rhode Island Medicaid's long-term care program
 - **Objective 1:** To rebalance the State's existing long-term care system with home- and community-based services
 - **Objective 2:** To increase the utilization of home- and community-based services in Rhode Island
 - **Objective 3:** To modify the State's income and resource eligibility requirements for Medicaid-funded long-term care services, specifically the rules pertaining to institutionalized spouses and continuous periods of institutionalization
- **Long-term Care Goal 2:** To establish objective, needs-based level of care determinations for Medicaid long-term care applicants and beneficiaries

- **Objective 1:** To develop systems for the delivery of needs-based level of care determinations for Medicaid LTC applicants and beneficiaries focused upon identifying applicants' medical, behavioral and social needs which could impact their ability to remain safely in home- and community-based settings
- **Long-term Care Goal 3:** To limit the rate of growth of the State's Medicaid budget
 - **Objective 1:** To control expenditure growth by implementing the objectives for Goals 1 and 2
 - **Objective 2:** To implement selective contracting based upon Rhode Island's purchasing analyses
 - **Objective 3:** To prevent or delay growth in Medicaid eligibility for full benefits by instituting Medicaid claiming for selected populations and/or services using costs not otherwise matchable (CNOM) authority
 - **Objective 4:** To promote the delivery of case management services for beneficiaries through organized systems of care
- **RIt Care Goal 1:** To increase access to and improve the quality of care for Medicaid families eligible for the Demonstration
 - **Objective 1:** To reduce uninsurance in the expansion population groups eligible for the Demonstration
- **RIt Care Goal 2:** To expand access to health coverage to all eligible pregnant women and all eligible uninsured children and adults
 - **Objective 1:** To provide all enrollees in the Demonstration with a *medical home*
 - **Objective 2:** To improve access to health care for populations eligible for the Demonstration
 - **Objective 3:** To increase the appropriate use of inpatient hospitals and hospital emergency departments
 - **Objective 4:** To reduce infant mortality
 - **Objective 5:** To improve maternal and child health outcomes
 - **Objective 6:** To have a high satisfaction level with the Demonstration project among enrolled populations
- **RIt Share Goal 1:** To expand access to health coverage to all eligible pregnant women and all eligible uninsured children and adults

- **Objective 1:** To provide a cost-effective alternative to Medicaid eligibility through mandatory participation in employer-sponsored insurance (ESI)
- **Extended Family Planning Goal 1:** To control the rate of growth in the Medicaid budget for the eligible population
 - **Objective 1:** To avert future Medicaid-funded births by providing family planning services to Medicaid-eligible women who lost their Medicaid eligibility 60 days post-partum
 - **Objective 2:** To increase the inter-birth spacing for Medicaid-funded births by providing family planning services to Medicaid-eligible women who lost their Medicaid eligibility 60 days post-partum
- **CNOM Budget Population Goal 1:** To increase access to and improve the quality of care for Medicaid families eligible for the Demonstration
 - **Objective 1:** To reduce uninsurance in the expansion population groups eligible for the Demonstration
- **CNOM Budget Population Goal 2:** To expand access to health coverage to all eligible pregnant women and all eligible uninsured children and adults
 - **Objective 1:** To provide all enrollees in the Demonstration with a *medical home*
 - **Objective 2:** To improve access to health care for populations eligible for the Demonstration
 - **Objective 3:** To increase the appropriate use of inpatient hospitals and hospital emergency departments
 - **Objective 4:** To reduce infant mortality
 - **Objective 5:** To improve maternal and child health outcomes
 - **Objective 6:** To have a high satisfaction level with the Demonstration project among enrolled populations
- **CNOM Budget Population 9 & Budget Services Group 4 Goal 1:** To provide a limited benefit package for children with special health care needs (CSHCN) who have not been voluntarily placed in State, custody, thereby allowing them to function in the least restrictive environment
 - **Objective 1:** To provide a cost-effective, home- and community-based alternative to institutional care for CSHCN

- **CNOM Budget Population 10 Goal 1:** To assist elders over the age of 65 to maintain optimum health and functioning in the least restrictive environment by providing home- and community-based services to qualified beneficiaries
 - **Objective 1:** To improve client stability and functioning in the community
 - **Objective 2:** To provide a cost-effective alternative to institutional care
- **CNOM Budget Population 15 Goal 1:** To provide a limited benefit package for adults with disabilities who are at risk for long-term care (LTC), thereby promoting their ability to function in the least restrictive environment
 - **Objective 1:** To increase adults with disabilities' access to a designated set of home- and community-based services
 - **Objective 2:** To provide a cost-effective, home- and community-based alternative to institutional care for adults with disabilities
- **CNOM Budget Population 16 Goal 1:** To provide cost-effective services that will ensure recipients receive the appropriate services in the least restrictive and most appropriate setting
 - **Objective 1:** To increase access for uninsured adults with mental illness and/or substance abuse problems to a designated set of community-based services
 - **Objective 2:** To reduce the number of Medicaid-paid psychiatric inpatient admissions for drug/alcohol admissions for drug/alcohol detoxification
 - **Objective 3:** To reduce the average inpatient MI/SA length of stay (ALOS)
 - **Objective 4:** To reduce inpatient readmissions within 30 days of MI/SA hospital discharges
- **CNOM Budget Population 17 Goal 1:** To provide a limited benefit package for children less than 18 years of age who are at risk of institutional care, thereby allowing these children to function in the least restrictive environment
 - To increase access for children at risk of requiring institutional care who are not Medicaid eligible to a designated set of home- and community-based services available to Budget Population 17
 - To provide a cost-effective home- and community-based alternative to institutional care for children less than 18 years of age who are at risk of institutional care

CHAPTER III

DEMONSTRATION EVALUATION REQUIREMENTS

Paragraph 94 of the Special Terms and Conditions (STCs) requires the following with respect to the evaluation design for the Demonstration:

“State Must Separately Evaluate Components of the Demonstration. As outlined in subparagraphs (a) and (b), the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding both components. The State must submit to CMS for approval a draft evaluation design no later than July 1, 2009. The evaluation must outline and address evaluation questions for both of the following components:

- a) **Rhode Island Global.** At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the entire Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. The evaluation must address the adequacy and appropriateness of the benefit coverage, safety and outcome of the LTC reform and expansion groups, especially the Extended Family Planning, HIV Services, Elders 65 and Over and Parents pursuing behavioral health services expansion groups. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.
- b) **Focused Evaluations.** The separate components of the demonstration that must be evaluated include but are not limited to the following:
 - a) LTC Reform, including the HCBS-like and PACE-like programs;
 - b) RIte Care;
 - c) RIte Share;
 - d) The 1115 Expansion Programs (Limited Benefit Programs), including but limited to:
 - (1) Children and Families in Managed Care and Continued eligibility for RIte Care parents when kids are in temporary state custody;
 - (2) Children with Special Health Care Needs;
 - (3) Elders 65 and Over;
 - (4) HCBS for Frail Elders, HCBS for adults with disabilities, HCBS for Kids in residential diversion and HCBS for at risk/Medicaid eligible youth;
 - (5) Uninsured adults with MI/SA problems;
 - (6) Coverage of detection and intervention services for at risk young children;
 - (7) HIV Services;

- (8) Administrative Process flexibility; and
- (9) Extended Family Planning Program. The draft design must include a discussion of the goals, objectives and evaluation questions specific to this component of the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the extended family planning program, particularly among the target family planning population, during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the extended family planning program shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation. The report should also include an integrated presentation and discussion of the specific evaluation questions (including those that focus specifically on the target population for the family planning program) that are being tested. At a minimum, the following data elements will be included in the measurement methodology:”

Measure	Number	Percentage Change
Enrollment		
Averted Births		
Inter-birth Spacing		
Family Planning Patients Receiving a Clinical Referral for Primary Care	(Estimate may be based on a sample)	

The Rhode Island Executive Office of Health and Human Services (EOHHS) submitted the required Draft Evaluation Plan to CMS on July 17, 2009

Paragraph 96-c of the STCS set forth the following requirement:

“The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide Comments within 60 days after receipt of the report. The State must Submit the final evaluation report within 60 days after receipt of CMS Comments.”

1. Summary

The remainder of this document addresses these requirements. It should also be noted that Paragraph 98 of the STCs provides:

“The State will keep in place the existing quality systems for the waivers/demonstrations/programs that currently exist and will remain intact under the Global 1115 (RItE Care, Rhody Health, Connect Care Choice, RItE Smiles, and PACE). For its Home and Community Based Services System under the Global 1115, the State will utilize a QA/QI plan consistent with the Quality rubric in the 1915(c) waiver

program that will assure the health and welfare of program participants. This QA/QI system will be based on the system utilized in the current aged/disabled waiver, number 0040.90.R5. Components must be added to the QA/QI to monitor and evaluate the health and welfare of section 1115 expansion programs with limited benefit coverage.”

CHAPTER IV

DEMONSTRATION EVALUATION DESIGN AND STATUS

4.1 Demonstration Evaluation Design

After award of the Demonstration, EOHHS formed a Global Waiver Quality and Evaluation Workgroup, which generally meets monthly. The Workgroup is comprised of EOHHS and departmental program component representatives as well as contractor representatives. Initially, the Workgroup took up the drafting of the required evaluation design. The July 17, 2009 *Draft Evaluation Design* submitted to CMS had a separate evaluation design for the following program components:

- **Long-Term Care (LTC) Reform**
- **RItE Care**
- **RItE Share**
- **Extended Family Planning**
- **Focused Evaluations of Specific Budget Populations**

For each component of the Demonstration for which a specific evaluation design is required, the evaluation design delineates the following:

- **Goals**
- **Objectives**
- **Evaluation Questions**
- **Data Source(s)**
- **Illustrative Measure(s)**
- **Periodicity**

It should be noted that the *Draft Evaluation Design* contained the following appendices to fulfill requirements of the STCs:

- RItE Care Demonstration Project Evaluation Design
- Extended Family Planning Program (EFP) Evaluation Design

Appendix A to this document contains the detailed evaluation design for each program component of the Demonstration.

4.2 Demonstration Evaluation Status

Since the submission of the *Draft Evaluation Design*, the Workgroup meetings have focused on review of the status of the evaluation design and findings to date. Among the program components reviewed have been:

- RIte Smiles
- RIte Care
- Rhody Health Partners
- Children’s Respite Care
- Extended Family Planning
- Long-Term Care
- CEDARR Health Homes
- PACE
- Rhode to Home (Rhode Island’s *Money Follows the Person* Demonstration grant)
- RIte @ Home (EOHHS’ Shared Living program)

Table 1 shows a summary of the status of the various components of the Demonstration included in the *Draft Evaluation Design*.

Table 1

Status of the Evaluation Design

Demonstration Evaluation Design Component	Status
Long-Term Care Reform	The Lewin Group report <i>An Independent Evaluation of Rhode Island’s Global Waiver</i> dated December 6, 2011
RIte Care	Ongoing since 1995 – annual reports submitted to CMS prior to Global Waiver
RIte Share	Ongoing since 2002 – annual reports submitted to CMS prior to Global Waiver
Extended Family Planning	Results of Survey of Planning Patients Receiving a Clinical Referral for Primary Care submitted to CMS on January 19, 2012
Focused Evaluations for Expansion Groups	In Development

It should be noted that EOHHS submits a quarterly reports to the Rhode Island General Assembly’s Senate Committee on Health and Human Services. These reports are posted on the EOHHS Website, the most recent of which can be accessed at:

http://www.eohhs.ri.gov/documents/documents12/Senate_Quarterly_Report_09_28_12.pdf

These reports form a substantial part of the Global Waiver quarterly report submissions to CMS.

CHAPTER V

DEMONSTRATION EVALUATION FINDINGS

This chapter presents evaluation findings for:

- Long-Term Care
- RIte Care and Rhody Health Partners
- Extended Family Planning

1. Long-Term Care Evaluation Findings

The Lewin Group, in collaboration with the New England States Consortium Systems Organization (NESCSO) and EOHHS, conducted an evaluation of the Global Waiver. The purpose of the evaluation was to conduct an independent assessment of the impact of the Global Waiver on Rhode Island's Medicaid expenditures. The evaluation focused on three areas:

- Have Global Waiver and budget initiatives that changed Rhode Island's long-term care processes, procedures, and provider payments affected enrollment, utilization, and cost of services and supports provided the elderly and adults with disabilities in home and community based versus institutional settings?
- Have Global Waiver budget initiatives designed to reduce cost through case management by providing each Medicaid beneficiary with a medical home affected Medicaid expenditures and improved health outcomes, particularly those beneficiaries with disabilities?
- Have the Global Waiver initiatives facilitated the State's efforts to ensure every Medicaid beneficiary has the right services, at the right time, in the right setting?

Regarding long-term care (LTC) cost and utilization, the Global Waiver built on the State's strategic plan to rebalance the LTC services and supports initiated through the State's Real Choices Systems Transformation Grant which began in 2006. The initiatives to rebalance the LTC system include:

- Changes to the clinical level of care policy and process including development of a preventive level of care
- Initial steps to address the needs of high cost utilizers
- Nursing home diversion and transition projects
- Promoting the availability of community-based services as an alternative to nursing home placement
- Removing delegated authority from hospital discharge planners
- Improving shared living arrangements

The Lewin Group analyzed Medicaid claims data for State Fiscal Years (SFY) 2008 through 2010. The Lewin Group concluded⁶:

“This analysis of LTC expenditures found that the Global Waiver was successful in re-balancing the long term care system resulting in utilization of more appropriate LTC services. During the study period the average number of nursing home users fell by 3.0 percent from SFY08 to SFY10. During the same period the average number of home and community base service users rose by 9.5 percent. These Global Waiver strategies clearly helped the state to re-balance the delivery of LTC services, resulting in savings of \$35.7 million during the three year study period according to our estimates.”

Regarding LTC rate-setting initiatives, the State implemented two key budget initiatives to reduce the rate of growth in nursing home rates:

- Implementation of a nursing home acuity adjuster
- Nursing facility rate costs for direct labor costs

The Lewin Group concluded⁷:

“The average cost per day in a nursing home rose by an average of 1.1 percent during the study period, while the acuity of the enrolled population rose by more than 5 percent. The increase was consistent with the inflation rate during this period. The increase in the acuity of the enrolled population was the result of the Global waiver home diversion and transition initiatives. The rate initiatives resulted in savings of \$15 million according to our estimates during SFY10.”

Regarding improved case management, children with special health care needs (CSHCN) and adults with disabilities were enrolled mandatorily into managed care during SFY10 to ensure that every beneficiary had a medical home. CSHCN were enrolled in RItE Care and the adults with disabilities were enrolled in either Rhody Health Partners or Connect Care Choice. The Lewin Group concluded⁸:

“Analyses of total expenditures for members in these programs in comparison to members in unmanaged fee for service found that these case management programs were clearly cost effective. An analysis of the utilization of medical services by members enrolled in care management programs found evidence of lower emergency room utilization and improved access to physician services. These programs resulted in savings in excess of \$5 million during SFY10, based on our most conservative estimates.”

Regarding the right services, at the right time, in the right setting, evaluation focused on a cohort of CSHCN and adults with disabilities transitioned to managed from SFY09 to SFY10. The Lewin Group concluded⁹:

⁶The Lewin Group. *An Independent Evaluation of Rhode Island's Global Waiver*, December 6, 2011 p.1

⁷ *Ibid.* p. 2.

⁸ *Ibid.*

⁹ *Ibid.*

“The utilization of inpatient care, emergency room visits and physician visits for members in the cohort was computed each year using claims and encounter data. All three groups experienced a decrease in the number of emergency room visits from SFY09 to SFY10 and an accompanying increase in the number of physician visits during SFY10.”

The Lewin Group concluded overall¹⁰:

“In summary, the Global Waiver and budget initiatives introduced by the state have been highly effective in controlling Medicaid costs in Rhode Island and improving members’ access to more appropriate services.”

Please refer to Attachment B for a full copy of this evaluation entitled *An Independent Evaluation of Rhode Island’s Global Waiver*.

This independent evaluation may also be accessed on the EOHHS’ Website:
http://www.eohhs.ri.gov/documents/documents11/Lewin_report_12_6_11.pdf

2. RItE Care and Rhody Health Partners

Since the advent of the Global Waiver, evaluation of RItE Care, the State’s Medicaid managed care program for children, families and pregnant women, and Rhody Health Partners, the State’s Medicaid managed care program for adults with disabilities, has focused on quality of care. Medicaid beneficiaries are enrolled in either Neighborhood Health Plan of Rhode Island (NHPRI) or UnitedHealthcare Community Plan of Rhode Island (UHCP-RI). IPRO, the State’s external quality review organization (EQRO), concluded in its October 2012 report entitled *Rhode Island Medicaid Managed care Program Annual External Quality Review Technical Report: Reporting Year 2011*:

“IPRO’s external quality review concludes that the Rhode Island Medicaid managed care program and its participating Health Plans, NHPRI and UHCP-RI, have had an overall positive impact on the accessibility, timeliness and quality of services for Medicaid recipients. This is supported by the fact that both Health Plans achieved an *Excellent* NCQA accreditation status and ranked among or above the top ten (10) percent of Medicaid Health Plans evaluated by the NCQA in 2011, with NHPRI ranking 8th within the top ten (10) Health Plans, and UHCP-RI improving substantially from its 2010 ranking of 26th to its 2011 ranking of 16th.

Common strengths for both Health Plans include: strong performance on access to care and provision of well care and preventive screening services for children and adolescents, excellent access to ambulatory and preventive care for adults and generally high levels of member satisfaction.”

3. Extended Family Planning

¹⁰ Ibid

The Extended Family Planning (EFP) program component of the Global Waiver began on August 1, 1994. From August 1, 1994 to September 30, 2008, eligibility for EFP was for women up to 250 percent of the Federal poverty level (FPL) who had been enrolled in Medicaid managed care, who had a Medicaid-funded birth, and who had lost their Medicaid eligibility 60 days postpartum. These women could be enrolled in EFP, where they would receive only family planning benefits for up to two years as a means to avert a future Medicaid-funded birth. The upper threshold for EFP was reduced from 250 percent of the FPL eligibility level to 200 percent of the FPL, effective October 1, 2008.

The goal of the EFP component of RItE Care has been and continues to be an integral component of one of Rhode Island’s three overarching goals: to control the rate of growth in the Medicaid budget for the eligible population. With respect to EFP, the objectives have been and continue to be:

- To avert future Medicaid-funded births by providing family planning services to Medicaid-eligible women who lost their Medicaid-eligibility 60 days post-partum
- To increase the inter-birth spacing for Medicaid-funded births by providing family planning services to Medicaid-eligible women who lost their Medicaid-eligibility 60 days post-partum

The EFP benefit covers: (1) gynecological services, (2) laboratory services, (3) family planning procedures, and (4) family planning supplies.

EFP enrollees receive their EFP benefits through the Medicaid Managed Care Health Plan in which they were enrolled while pregnant. Health Plans are paid an actuarially determined monthly capitation rate for women enrolled in EFP.

Table 2 below shows the number of averted births attributable to EFP from 1998 through 2010. As the table shows, there were 4,522 averted births over that time period.

Table 2

RItE Care Averted Births: 1998 - 2010

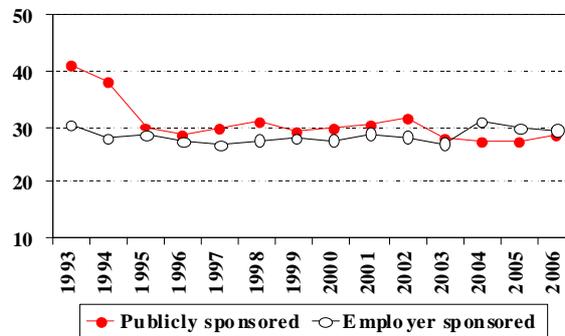
Year	Expected RItE Care Births	Averted RItE Care Births	Cumulative Averted Births
1998	4,258	298	298
1999	4,637	645	943
2000	4,812	336	1,279
2001	5,108	472	1,751
2002	5,328	418	2,169
2003	5,416	300	2,469
2004	5,564	442	2,911
2005	5,622	391	3,302

2006	5,641	402	3,704
2007	5,376	102	3,806
2008	5,125	(15)	3,791
2009	5,132	240	4,031
2010	5,258	491	4,522

Figure 1 below shows that the gap in the inter-birth interval between Medicaid and commercially insured patients has virtually disappeared since RItE Care was implemented.

Figure 1

**Percent of Women with Short Interval Between Births (<18 months)
by Insurance Status**



As noted earlier, the State was obligated by the STCs to conduct a survey of EFP enrollees referrals for primary care. The sample universe for the survey consisted of women continuously enrolled in EFP for 330 to 365 days from January 2010 through June 2011. There were 673 such women. After eliminating women with no telephone or who did not speak English, the final sample universe was 221 women from which the random sample of 30 completed surveys were done.

A total of 119 calls were made in order to complete the 30 surveys. Table 3 shows the outcome of these calls.

**Table 3
EFP Survey Calls**

Outcome of Call	Number
Answering Machine	34
Completed Survey	30
Not in Service	13
No Answer	12
Spoke Spanish	9
Not Home	7
Wrong Number	5
Call Back	4

Busy Signal	3
No Incoming Calls	2
Total	119

The responses to the survey are shown below.

Figure 2, which is depicted on the following page, shows that that the vast majority of women surveyed had a family planning visit after the birth of their child.

Figure 2

Ever been or a Family Planning Visit since baby was born?

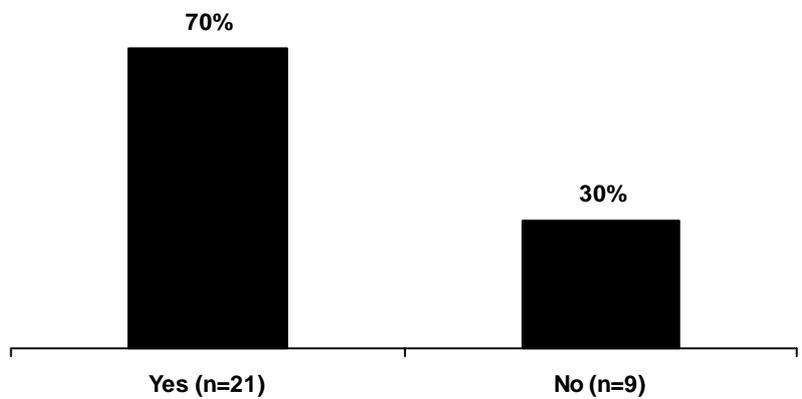


Figure 3 shows that only four respondents were referred for a primary care visit (clinical referral) while they were at a family planning visit.

Figure 3

At any Family Planning Visit were you referred for a Primary Care Visit?

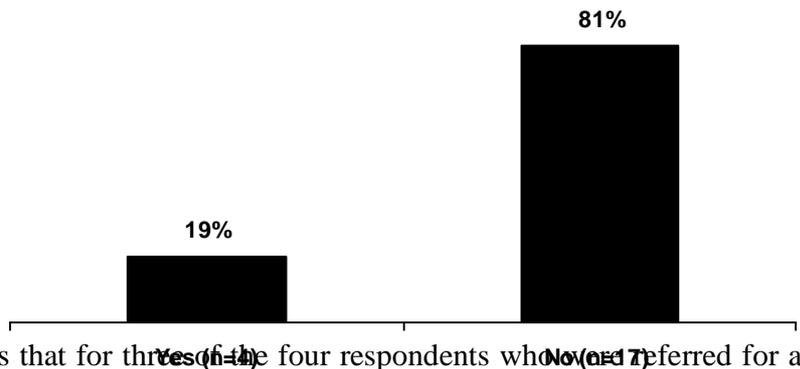


Figure 4 shows that for three of the four respondents who were referred for a primary care visit (clinical referral), they were referred to a physician's office, and the other to a community health center.

Figure 4

Where were you referred for Primary Care?

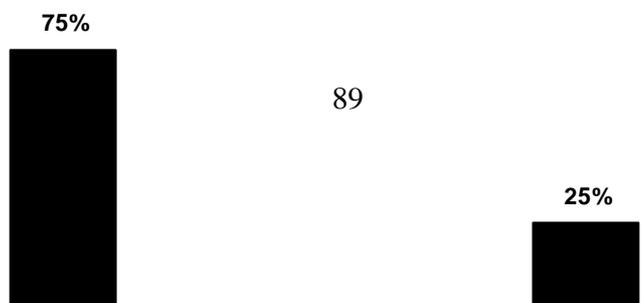
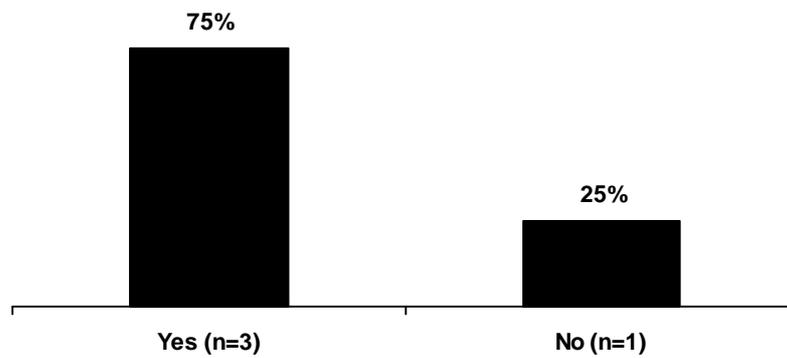


Figure 5 shows that for three of the four respondents who were referred for a primary care visit (clinical referral), they went for the primary care visit, and the other did not.

Figure 5

Did you go for a Primary Care Visit after referral?



ATTACHMENT 5: QUALITY MONITORING & EXTERNAL QUALITY REVIEW ORGANIZATION REPORTS

Summaries of External Quality Review Organization reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality and access to care provided under the demonstration, such as the CMS Form 416 EPSDT/CHIP reports.

Rhode Island Medicaid has organized its discussion about quality assurance monitoring based on the following series of quality improvement methods:

- External Quality Review (EQR)
- The State's Quality Strategy
- State Program Oversight Processes
- Rhode Island's Performance Goal Program
- State-mandated Quality Reporting
- State-mandated Quality Improvement Projects (QIPs)
- Accreditation by the National Committee for Quality Assurance (NCQA)
- CAHPS® surveys
- HEDIS® quality measures

External Quality Review: Based on Federal regulations, an annual External quality Review (EQR) of Rhode Island's Medicaid managed care program must be conducted by an independent contractor and submitted to the Centers for Medicare and Medicaid Services annually. Rhode Island Medicaid's commitment to the principle of *external quality review (EQR)* has been a long-standing one, actually predating the promulgation of Federal regulations that govern this important quality improvement process. Island Peer Review Organization, Incorporated (IPRO) is currently under contract with the Rhode Island Executive Office of Health and Human Services to conduct the EQR function for our State. In this role, the External Quality Review Organization (EQRO) is responsible for the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a managed care organization or its contractors furnish to Medicaid enrollees.

On an annual basis, the State's EQRO produces Health Plan-specific detailed technical reports to evaluate quality, timeliness, and access to health services. In addition to producing this annual series of Health Plan-specific reports, Rhode Island has commissioned its EQRO to generate an *aggregate EQR report*. The aggregate report provides the State with an analysis of key findings and recommendations for its Medicaid managed care program based upon the synthesis of information across the participating Health Plans.

In developing its annual EQR reports, the State's EQRO analyzes a rich and diverse set of qualitative and quantitative data, including the following:

- Each Health Plan’s accreditation survey findings from the National Committee on Quality Assurance¹¹
- Each Health Plan’s final, audited annual HEDIS®¹² scores and the report from its independent NCQA-certified HEDIS® auditor
- Provider network analyses: GeoAccess
- Each Health Plan’s contractually-mandated Quality Improvement Projects (QIPs)
- Health Plans’ performance in Rhode Island’s annual Performance Goal Program
- Each Health Plan’s annual CAHPS®¹³ member satisfaction survey report from the Health Plan’s NCQA-certified CAHPS® auditor
- Each Health Plan’s Quality Improvement/Quality Management Program Evaluation (which may also be referred to as the Health Plan’s annual QI report)
- The Health Plan’s Quality Improvement/Quality Management Plan
- Any special studies (such as CAHPS® Clinician and Group Surveys or ECHO Surveys)

Following the State’s receipt of the EQRO’s annual reports, these materials are sent to Rhode Island’s Regional and Federal CMS Officers.

In conjunction with the State’s annual continuous quality improvement cycle, findings from the annual EQR reports are also presented to Rhode Island Medicaid’s Quality Improvement Committee for discussion by the State’s team which oversees the MCOs.

Concurrently, each Medicaid-participating Health Plan is presented with the EQRO’s report, in conjunction with the State’s annual continuous quality improvement cycle, as well as correspondence prepared by Rhode Island Medicaid which summarizes the key findings and recommendations from the EQRO.

Subsequently, during the month of December, each Health Plan must make a presentation at the State’s Oversight and Management meeting, outlining the MCO’s response to the feedback and recommendations made by the EQRO. (The State’s approach to the monitoring and oversight of Health Plans that participate in Medicaid are discussed in great detail in the following section.)

In its 2012 Aggregate report, the State’s EQRO (IPRO, Incorporated) stated the following conclusion:

“IPRO’s external quality review concludes that the Rhode Island Medicaid

¹¹ Rhode Island requires its Medicaid-participating managed care organizations to maintain accreditation by the National Committee for Quality Assurance. When the State issued its Medicaid Managed Care Services Contract in September 2010, this requirement was reinforced by the establishment of a performance “floor”, to ensure that any denial of accreditation by the NCQA shall be considered cause for termination of the State’s Contract with a Health Plan. In addition, achievement of no greater than a provisional accreditation status by the NCQA shall require a Corrective Action Plan (CAP) within thirty (30) days and may result in Contract termination.

¹² HEDIS® is the acronym for the Healthcare Effectiveness Data and Information Set. HEDIS® is one of the most widely used sets of health care performance measures in the United States. The HEDIS® methodology is analyzed and updated annually by the NCQA’s Committee on Performance Measurement.

¹³ CAHPS® is the acronym for the Consumer Assessment of Healthcare Providers and Systems methodology, which is a nationally recognized methodology for measuring the satisfaction of Health Plan enrollees. The CAHPS® methodology has been developed under the aegis of the U.S. Department of Health and Human Services’ Agency for Healthcare Research and Quality (AHRQ).

Managed care program and its participating Health Plans, NHPRI and UHCP-RI, have had an overall positive impact on the accessibility, timeliness and quality of services for Medicaid recipients.”¹⁴

A version of the most recent Aggregate EQR report will be posted to the EOHHS Website.

State Quality Assurance Monitoring – Quality Strategy: Federal regulations that outline States’ responsibilities for overseeing Medicaid managed care systems have established a series of requirements for quality assessment and performance improvement. One essential requirement is a written *Quality Strategy*, which should be used for assessing and improving the quality of managed care services offered by all Managed Care Organizations. At a minimum, the Quality Strategy and the State’s MCO Contracts must include standards and procedures that:

- Assess the quality and appropriateness of care and services furnished to all enrollees
- Identify the race, ethnicity, and language spoken of each enrollee
- Regularly monitor and evaluate the MCOs’ compliance with these standards
- Identify any national performance measures that may be identified and developed by CMS in consultation with States and other relevant stakeholders
- Arrange for annual, external independent review of the quality outcomes and timeliness of, and access to, the services covered under each MCO contract
- Identify an information system that supports the initial and ongoing operation and review of the State’s quality strategy
- Delineate standards for access to care, structure and operations, and quality measurement and improvement

Rhode Island’s initial *Medicaid Managed Care Quality Strategy* was one of the first to be approved by Centers for Medicare and Medicaid Services (CMS) in April of 2005. It is comprehensive, including standards for access to care, managed care operations, quality, and reporting. Our State’s Quality Strategy serves as the basis for making program improvements and for developing measures that improve the cost-effectiveness of care. In 2006, CMS invited RI Medicaid to present an overview of our State’s Quality Strategy during a CMS Webinar for States. Subsequently, in 2008, CMS described Rhode Island’s Quality Strategy as one which:

... is comprehensive in addressing access, health care service, regulatory and contractual aspects of a State Health Quality Strategy. It encompasses a program approach with clearly outline strategy components, which is identified as a best practice nationally.

During the Autumn of 2011, Rhode Island Medicaid initiated an enhancement to its Quality Strategy. Building upon the core principles that had been previously approved by CMS for RItE Care, Rhode Island initiated this process in order to address the State’s newer Medicaid managed care programs: RItE Smiles, Connect Care Choice, and Rhody Health Partners. To elicit the participation of key stakeholders, the State’s Quality Strategy was presented to the Global Waiver’s Quality and Evaluation Work Group on 04/13/2012, to Rhode Island Medicaid’s

5 Annual External Quality Review – Technical Report Aggregate, Reporting Year 2012, IPRO, Inc., October 2012 (p. 6).

Consumer Advisory Committee (CAC) on 05/10/2012, and to Rhode Island Medicaid's senior administrators on 10/24/2012. To further engage with consumers and other key stakeholders, the proposed revision was also posted on the Rhode Island EOHHS Web-site. A copy of the Power Point presentation that was made to RI Medicaid Consumer Advisory Committee (CAC) on May 10, 2012, will be posted to the EOHHS Website.

In September of 2012, Rhode Island Medicaid was encouraged to participate in a pilot test of a *Quality Strategy Toolkit for States*, which was commissioned by CMS as our Federal partner initiated new oversight procedures regarding managed care quality. Our State was invited to offer its inputs regarding use of the *Toolkit* as well as the pilot test process. CMS asked that completed *Toolkit* be submitted in conjunction with the State's updated quality strategy draft. Our State's feedback was submitted to CMS in conjunction with the revised *Quality Strategy* and the completed *Toolkit* on 11/27/2012.

State Quality Assurance Monitoring – Program Oversight Processes (Managed Care): Rhode Island's Executive Office of Health and Human Services, Division of Health Care Quality, Financing and Purchasing (RI Medicaid) is responsible for the oversight of the managed care program. RI Medicaid continuously monitors and provides oversight to ensure that all Federal and State standards are met. Our collective goal is to ensure access to high quality care that enhances health outcomes, while containing costs.

On a monthly basis, RI Medicaid conducts oversight and management meetings with Neighborhood Health Plan of Rhode Island (NHPRI), UnitedHealth Care of New England (UHCNE) and UnitedHealth Care Dental (UHC Dental). These monthly meetings are conducted separately with each of the managed care organizations (MCOs); the meeting agendas focus upon both standing and emerging items. The following content areas are addressed on a cyclic, quarterly basis:

- Medicaid managed care operations (Jan, Apr, July, Oct)
- Medicaid managed care financial performance (Feb, May, Aug, Nov)
- Medicaid program integrity and quality improvement (Mar, June, Sep, Dec)

RI Medicaid and contractor staff provide continuous and intensive oversight, monitoring and technical assistance to ensure compliance with Medicaid requirements and when necessary take corrective action to enhance the provision of high quality, cost-effective care. RI Medicaid staff fulfills its responsibilities in several ways, including:

- **State Liaisons:** Highly qualified individuals who have managed care experience and intimate knowledge of the RI Medicaid program are assigned to each MCO (including UHC Dental). These professionals serve as the chief liaison between the MCO and RI Medicaid. Responsibilities include: monitoring compliance and contract performance, identification of problem areas, assisting in the development and implementation of corrective action plans, providing technical assistance to improve cost-effectiveness and ensuring that MCOs are incorporating changes in Federal and State rules and regulations.

- **Analytics:** Medicaid program requirements are complex and require reporting and analysis of timely information and data regarding the performance of each MCO. MCOs are required to submit information about financials, operations and service utilization through the encounter data system. (RI Medicaid maintains and operates a data validation plan to assure the accuracy of encounter data submissions). The MCOs are also required to submit a series of quarterly reports, such as those that provide information regarding the adjudication of informal complaints, grievances and appeals. RI Medicaid staff analyze MCO data and compare it to established standards/measures, industry norms and trends to identify areas that need to be reviewed to improve compliance with established standards and/or to improve program performance. Additionally, staff utilizes data modeling techniques to assess the impact of current trends or alternative improvement strategies.
- **Ongoing Evaluation/Review of Program Priorities & MCO Performance:** RI Medicaid conducts monthly internal staff meetings to discuss MCOs' attainment of performance goals and standards related to access, quality, health outcomes, member services, network capacity, medical management, program integrity and financial performance. RI Medicaid staff identifies strategies and develops recommendations for program improvements and assesses the feasibility and impact of potential changes in Medicaid to improve program operations.

State Quality Assurance Monitoring – Program Oversight Processes (Home- and Community-based Services): When administering any 1915(c) waivers, a Medicaid program is responsible for ensuring that the following six (6) assurances are met:

- 1) Level of Care: Persons enrolled in the waiver have needs consistent with an institutional level of care
- 2) Service Plan: Participants have a service plan that is appropriate to their need and that they receive the services and supports specified in the plan
- 3) Qualified Providers: Waiver providers are qualified to deliver services and supports
- 4) Health & Welfare: Beneficiaries' health and welfare are safeguarded and monitored
- 5) Financial Accountability: Claims for waiver services are paid according to State payment methodologies
- 6) Administrative Authority: The State Medicaid agency is involved in the oversight of the waiver and overall responsibility of the program

Historically the Medicaid Home and Community Based 1915(c) Quality framework has included the following key components:

- The design of a Quality Strategy which includes performance measures, methodology, and sampling strategy
- The monitoring of the implementation of the Quality Strategy and reporting on findings using performance measures
- The correction of non-compliance based on performance measures
- The implementation of corrective action when needed to improve performance

An integral part of such a Quality framework is the development of performance indicators based on the assurances listed above. The use of such performance measures provides ongoing monitoring of how the Medicaid program is meeting such assurances. When the Rhode Island Global Consumer Choice Impact 1115 Demonstration Waiver was approved and implemented in 2009, the State followed the guidance set forth in the STCs, which called for remaining consistent with the Quality framework that had been utilized under Rhode Island's former 1915(c) waivers. As such, many of the current methods utilized for ongoing monitoring and performance measures are based on that Quality framework, and include but are not limited to the following elements:

- Case Record Review and Chart Audits
- Provider monitoring, including BCI checks
- Client Surveys, including home visits and interviews
- Fiscal & Eligibility Review, including utilization reviews, and
- Risk Assessments

On a quarterly basis the HCBS Oversight and Monitoring team meet to review a case from each month in the previous quarter. The purpose of the review is to identify and address quality concerns and develop system change recommendations as indicated. In addition to these quarterly meetings, key evaluation findings and monitoring outcomes and updates are presented to the Global Waiver Quality and Evaluation workgroup on a regular basis.

State Quality Assurance Monitoring – Program Oversight Processes (Program All-Inclusive for the Elderly (PACE)): CMS- and RI EOHHS- approved providers are responsible for providing the full scope of Medical Assistance State Plan categorical and medically needy services and the additional services (multidisciplinary assessment & treatment planning, case management services, personal care, homemaking, rehabilitation services, social work, transportation, nutritional counseling, recreational therapy, minor home modifications, and specialized medical equipment and supplies) to PACE enrollees. PACE in Rhode Island also functions as an adult day center and is licensed by the Rhode Island Department of Health, with collaborative oversight and monitoring by CMS and RI EOHHS.

Federal regulations outline PACE quality requirements as established under the Social Security Act and are requisite elements in the PACE program agreement between the PACE organization (PACE Organization of Rhode Island, Incorporated), CMS, and the State's Administering Agency (RI EOHHS). Collaboration amongst the three entities is expected on the development and implementation of quality of life outcomes. One essential requirement is the development of Quality Assessment and Performance Improvement Plan (QAPI). The QAPI must be reviewed annually by the PACE governing body and should delineate the following:

- Areas in which the organization should improve or maintain the delivery of services and patient care. Specific structure, process, and outcome measures include, but are not limited to the following:
 - Utilization of services (reduced hospitalization and ED visits)

- Participant and caregiver satisfaction
 - Outcome measures derived from data collected during participant assessments
 - Effectiveness and safety of staff-provided and contracted services
 - Non-clinical areas including grievances and appeals
 - Development and implementation of plans of action to improve or maintain quality of care
- Documentation and dissemination of the results of the QAPI activities to the PACE staff and contractors will be added to the EOHHS Website.

PACE holds monthly Quality meetings to review progress on its quality improvement goals, the results of which are reported every two years as part of the CMS/EOHHS site visit review. The measures identified as part of this process are set by ongoing needs assessment and CMS recommendations per the site visit review. As part of the local Oversight and Monitoring of the PACE program, a calendar of quarterly meetings was recently established. The goal of these quarterly meetings is to discuss operational, financial, and quality and compliance issues and concerns. As part of this process PACE has submitted to the RI EOHHS their QAPI Plan and results from 2011, which include key findings from its quarterly QI measurement, and Patient Satisfaction survey outcomes. The State is also in the process of developing and implementing a disenrollment survey with individuals who voluntarily dis-enrolled from PACE, in order to identify any trends and opportunities for the program.

RI EOHHS is required to monitor dis-enrollment, specifically involuntary dis-enrollments (for example, if a person moves out of the state). This disenrollment review process is completed by an internal committee at the State level, which must review the request and determine its appropriateness. The final outcome of this process is reported to CMS. To date, most of the voluntary dis-enrollments have been related to a person's desire to continue seeing their established physician, instead of the PACE physician. A grid of all voluntary dis-enrollments is provided to CMS, which includes a statement of the voluntary disenrollment (i.e., the concrete reason) and code. As part of the disenrollment process, whether voluntary or involuntary, it is PACE's responsibility to ensure that a transitional care plan is established, including but not limited to the enrollee's Part D plan, PCP, and core waiver services.

Additionally, CMS requires PACE to report both aggregate and individual-level data to CMS and the RI EOHHS for monitoring a PACE organization's performance, including the following Level One indicators:

- Routine Immunizations
- Grievances and Appeals
- Enrollments
- Dis-enrollments
- Prospective Enrollees
- Readmissions
- Emergency (Unscheduled) Care

- Unusual Incidents, and
- Deaths

PACE must also report any Level Two occurrences, which are categorized as reportable incidents, including but not limited to death, infectious disease outbreaks, falls and pressure (decubitus) ulcers. Due to the sensitive and emergent basis of Level Two reporting there are specific requirements: 1) Level Two reporting must be submitted to CMS and the RI EOHHS within 48 hours of the determination that a Level Two incident has occurred. Subsequently, PACE must demonstrate the completion of an internal investigation, which must begin within 24 hours of reporting the incident, and be finalized within 30 days. PACE must also conduct a root cause analysis of the occurrence, including the identification of any “system” failures and improvement opportunities.

In addition, the PACE organization must prepare a case presentation for discussion on the call with its Federal and State administrators. Per CMS requirements, when preparing any Level Two case presentations, the PACE organization includes the following information:

- Summary of the care history
- Age and gender of participant
- Date of enrollment into the program
- Significant diagnoses
- Participant’s degree of involvement in PACE program
- IDT team’s main concerns related to participant prior to event
- Summary of the event
- Precipitating/contributing factors
- Participant’s involvement/actions surrounding the event
- Immediate actions taken
- Participant’s status
- Working relationship with contracted facility, contracted services (if applicable)
- Compliance with organization’s established policies and procedures
- Identification of risk points and their potential contribution to the event, and
- As appropriate, proposed improvements in policies, training, procedures, systems, processes, physical plant, staffing levels, etc., to reduce future risks

As described above, the rules governing PACE at the local level are prescribed by CMS (Medicare). A site visit is conducted by both CMS and DHS/OHHS every two years. The site visit is led by CMS, however internal clinical oversight is conducted by the State as part of the site visit. For example, Grievance and Appeal adjudication is managed internally at PACE, but oversight of this process is a significant element of the CMS site visit, which is conducted in collaboration with RI EOHHS. During the site visit, all relevant policies and protocols are reviewed, including the documentation of grievances and how each grievance was resolved.

State Quality Assurance Monitoring – Rhode Island’s Performance Goal Program: In 1998, RI Medicaid established a performance-based system that provides financial incentive awards to the MCOs that meet or exceed established quality metrics. Rhode Island was the 2nd state in the Nation to establish a performance-based system that promotes value-based purchasing.

A significant number of the measures which are included in the State’s Performance Goal Program are from standardized measurement sets: a) the NCQA’s HEDIS® methodology and b) the AHRQ’s CAHPS® methodology. Inclusion of these measures affords Rhode Island Medicaid with the opportunity to benchmark its performance against Medicaid Health Plans nationwide, using the Quality Compass for Medicaid® methodology. For each HEDIS® and CAHPS® measure, Quality Compass for Medicaid® delineates a count of the number of Medicaid Health Plans nationwide that had reportable results and provides comparative percentile rankings.

Currently, Rhode Island Medicaid’s Performance Goal Program has eight (8) major domains, which focus on the following:

- Member Services: Four (4) State-specified measures
- Medical Home/Preventive Care: Eighteen (18) measures¹⁵
- Women’s Health: Two (2) HEDIS® measures
- Chronic Care: Four (4) HEDIS® measures
- Behavioral Health: Three (3) HEDIS® measures
- Cost Management: One State-specified measure
- Initial Health Screenings Are Completed within Contractual Timeframes: For new RItE Care for Children with Special Health Care Needs (CSHCN) and Rhody Health Partners Enrollees
- Care Management Plans Are Evaluated and Updated within Contractual Timeframes: For RItE Care for CSHCN and Rhody Health Partners Enrollees

An on-site review is conducted at each Health Plan by representatives of the EOHHS. This process includes interviews with Health Plan staff as well as the review of random sample of care management records, grievance and appeal files, and documents, such as policies and procedures, call logs, and Member Handbooks.

Findings from the annual Performance Goal Program are shared internally with Rhode Island Medicaid’s Quality Improvement Committee, to foster discussion by the State’s team which oversees the MCOs. In addition to providing the measure-specific findings from the sentinel year, results are trended over a three-year period in order to help discern changes over time.

Detailed written summaries are also presented to the Health Plans. Any areas warranting performance improvement are highlighted, both within the summary report and in the accompanying cover correspondence. As noted previously, four (4) of the twelve (12) monthly Oversight and Monitoring meetings that are conducted with each Health Plan focus on quality improvement. At the August meeting, each Health Plan must present its action plan for

¹⁵ In the Medical Home/Preventive Care domain, there are two State-specified measures and the remainder are HEDIS® and CAHPS® measures.

remediation for any of the Performance Goal Program's HEDIS® or CAHPS® measures that do not meet the contractually-mandated Quality Compass for Medicaid® thresholds. Subsequently, at the December meeting, each Health Plan must outline the interventions that it will undertake to address any areas of low performance on any of the Performance Goal Program's State-specified measures.

On an annual basis, a summary from the annual Performance Goal Program is posted on the Rhode Island EOHHS Web-site.

State Quality Assurance Monitoring – State-mandated Quality Reporting: Rhode Island Medicaid requires its participating MCOs to submit a comprehensive series of standing quarterly monitoring reports, which are used for oversight and monitoring of the State's managed care program. In the following series, each report that has been flagged with an asterisk (*) must be disaggregated by the Health Plan, to provide program-specific information for each of its various Medicaid enrollment populations (such as Rhody Health Partners and RIte Care for Children with Special Health Care Needs):

- CAITS* (Children and Adolescents Intensive Treatment Services)
- Care Management*
- Communities of Care*
- Fraud and Abuse Investigations
- Generics First*
- Grievances and Appeals*
- High Cost (>\$25,000) Cases
- Informal Complaints*
- Pain Management
- Pharmacy Home*

The findings from these reports are analyzed on a quarterly basis with each Health Plan during the State's series of Oversight and Monitoring meetings. Receipt of this ongoing series of reports allows Rhode Island Medicaid to identify emerging trends, any potential barriers or unmet needs, or quality of care issues.

State Quality Assurance Monitoring – Quality Improvement Projects (QIPs): Based on Federal managed care regulations, Medicaid managed care organizations must conduct a series of Performance Improvement Projects (also known as *Quality Improvement Projects* or "QIPs") on an annual basis and submit these to Rhode Island Medicaid. In conformance with Rhode Island's *Quality Strategy*, IPRO, Incorporated (the State's External Quality Review Organization) analyzes each Health Plan's QIPs. Subsequently, IPRO's feedback is presented in its series of annual External Quality Review (EQR) reports to Rhode Island Medicaid, the Health Plans, and the Centers for Medicare and Medicaid Services.

When Rhode Island Medicaid and its participating Health Plans entered into the 2010 *Medicaid Managed Care Services Contract*, requirements that focus on the mandatory Quality Improvement Projects were enhanced. Rhode Island Medicaid set several new requirements:

- Each Health Plan must conduct four (4) Quality Improvement Projects annually
- At least one QIP must address each of the following populations of interest:
 - Children with Special Health Care Needs (CSHCN)
 - Disabled adults who are enrolled in Rhody Health Partners
 - Members who are enrolled in the Communities of Care initiative

Rhode Island Medicaid requires that each Health Plan organize its Quality Improvement Projects using a template that was developed by the National Committee for Quality Assurance (NCQA) for accreditation and certification purposes. The Quality Improvement Activity (QIA) form (will be posted to the EOHHS Website) provides a robust set of standards and guidance for summarizing quality improvement activities.

As noted previously, on an annual basis the State requires each Health Plan to present its feedback to the annual External Quality Review (EQR) report and its plan for addressing recommendations set forth by the State’s EQRO. This meeting takes place during the month of December and the agenda also focuses on the Health Plans’ year-end report of the outcomes of their four (4) QIPs. Findings from the QIPs are also provided to the State’s EQRO for validation purposes.

Rhode Island Medicaid sets forth the areas of focus for the Health Plans’ annual QIPs, based upon our synthesis of qualitative and quantitative measures, such as HEDIS® and CAHPS® results and findings from the State’s annual Performance Goal Program, as well as the recommendations put forward by the EQRO. For CY 2013, the State has established the following areas of focus for the QIPs that will be conducted by its participating Health Plans.

State-mandated QIP Measures for CY 2013

QIP Measure	Measure Steward
Initial Health Screenings Are Conducted with New RHP and RIt Care for CSHCN Members within 45 Days of Enrollment	RI EOHHS
Chlamydia Screening in Women	NCQA/HEDIS®
Follow-up Care for Children Prescribed ADHD Medication	NCQA/HEDIS®
Antidepressant Medication Management	NCQA/HEDIS®

State Quality Assurance Monitoring – CMS Form 416 EPSDT/CHIP Reporting: The *State’s CMS 416: Annual EPSDT Participation Report* is produced annually and focuses on Medicaid’s Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program. The CMS 416 includes but is not limited to the following measures:

- Screening Ratio
- Participant Ratio
- Total Eligibles Receiving Any Dental Services
- Total Eligibles Receiving Preventive Dental Services
- Total Eligibles Receiving Dental Treatment Services
- Total Eligibles Receiving a Sealant on a Permanent Molar Tooth

- Total Eligibles Receiving Dental Diagnostic Services
- Total Number of Screening Blood Lead Tests

For each measure, findings are segmented by age : < 1 year; 1 – 2 years; 3 – 5 years; 6 – 9 years; 10 – 14 years; 15 – 18 years; and 19 – 20 years.

On an annual basis, findings from the CMS 416 Report are presented to Rhode Island Medicaid’s Quality Improvement Committee for discussion by the State’s team which oversees the MCOs. Preliminary and final CMS 416 results are also shared with the State’s Medicaid participating Health Plans for their inputs. The CMS 416 is submitted to CMS as required

State Quality Assurance Monitoring – Use of CAHPS® Surveys: In 2011, RI Medicaid undertook a member satisfaction survey process, focusing on the State’s Rhody Health Partners (RHP) program. Although each Medicaid-participating Health Plan has included RHP enrollees in its annual CAHPS® survey methodology since the inception of the program, the State was eager to assess the satisfaction of this cohort of disabled adults with a survey focusing exclusively on RHP members.

Based on RI Medicaid’s analysis of existing member satisfaction survey instruments, a decision was made to use the Agency for Healthcare Research and Quality’s CAHPS® survey, which is endorsed by the National Quality Forum (NQF). Selection of the CAHPS® methodology afforded the State with the opportunity to benchmark its findings against the performance of other Medicaid managed care programs, through the use of the NCQA’s Quality Compass® for Medicaid. The Quality Compass® for Medicaid analytic tool delineates a count of the number of Medicaid Health Plans nation-wide that had reportable results for various CAHPS® measurement questions and provides comparative percentile rankings, which are set at the 10th, 25th, 50th, 75th, and 90th levels.

The English text version¹⁶ of Rhode Island’s survey will be posted to the EOHHS Website. In addition to using the standard CAHPS® survey instrument, RI Medicaid included several CAHPS® supplemental questions, focusing on the following content: Behavioral Health, Chronic Conditions, Mobility Impairments, and After-hours Care.

Findings from the survey were shared with key stakeholders, including Rhode Island Medicaid’s Consumer Advisory Committee (CAC) on 05/10/2012 and the Global Waiver’s Quality and Evaluation Work Group on 06/08/2012. This information was also presented to the State’s Medicaid-participating Health Plans. A copy of the presentation that was made to the Global Waiver’s Quality and Evaluation Work Group will be posted to the EOHHS Website.

Managed Care Organization (MCO) Quality Monitoring – Accreditation by the National Committee for Quality Assurance (NCQA): Rhode Island has required its Medicaid-participating Health Plans to be accredited by the NCQA since the inception of our State’s Medicaid managed care program in 1994. The NCQA is a private, 501 (c)(3) not for profit

¹⁶ The survey was also available in Spanish text.

organization, whose mission is to improve the quality of health care. Health Plans in every State, as well as the District of Columbia and Puerto Rico are NCQA accredited.

NCQA accreditation is considered the “gold standard” by both commercial and public health care purchasers. By virtue of requiring NCQA accreditation, the State has access to the results of the MCOs’ annual collection of the NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures.

When the State issued its *Medicaid Managed Care Services Contract* in September 2010, its NCQA accreditation requirement was reinforced by the establishment of a performance “floor”, to ensure that any denial of accreditation by the NCQA shall be considered cause for termination of the State’s Contract with a Health Plan. In addition, achievement of no greater than a provisional accreditation status by the NCQA shall require a Corrective Action Plan (CAP) within thirty (30) days and may result in Contract termination.

The NCQA’s accreditation process is a rigorous, comprehensive and transparent evaluation process through which the quality of the systems, processes, and results that define a Health Plan are assessed. Additionally, accreditation includes an evaluation of the actual results that the Health Plan achieves on key dimensions of care, service and efficiency. Specifically, NCQA reviews the Health Plans’ quality management and improvement, utilization management, provider credentialing and re-credentialing, members’ rights and responsibilities, standards for member connections, and HEDIS®/CAHPS® performance measures.

The NCQA’s accreditation survey process includes on-site and off-site evaluations conducted by survey teams composed of physicians and managed care experts who interview plan staff and review materials such as case records and meeting minutes. The findings of these evaluations are analyzed by a national oversight committee of physicians and an accreditation level is assigned based on a Health Plan's compliance with NCQA's standards and its HEDIS®/CAHPS® performance. Compliance with standards accounts for approximately 60% of the Health Plan’s accreditation scores, while performance measurement accounts for the remainder.

Health Plans are scored along five dimensions:

- **Staying Healthy:** An evaluation of Health Plan activities that help people maintain good health and avoid illness: Does the Health Plan give its doctors guidelines about how to provide appropriate preventive health services? Do members receive appropriate tests and screenings?
- **Getting Better:** An evaluation of Health Plan activities that help people recover from illness: How does the Health Plan evaluate new medical procedures, drugs and devices to ensure that patients have access to the most up-to-date care? Do doctors in the Health Plan advise patients to quit smoking?
- **Living with Illness:** An evaluation of Health Plan activities that help people manage chronic illness: Does the Health Plan have programs in place to help patients manage chronic conditions like asthma? Do diabetics, who are at risk for blindness, receive eye exams as needed?

- **Access and Service:** An evaluation of Health Plan members’ access to needed care and good customer service: Are there enough primary care doctors and specialists to serve all plan members? Do members report problems getting needed care? How well does the Health Plan follow-up on grievances?
- **Quality Providers:** An evaluation of Health Plan efforts to ensure that each doctor is licensed and trained to practice medicine and Health Plan members are happy with their doctors: Does the Health Plan check whether physicians have had sanctions or lawsuits against them? How do members rate their personal doctors or nurses?

Although the on-site accreditation occurs every three years, ratings are recalculated annually by the NCQA based on the most recent Accreditation Survey Findings and the latest HEDIS® results. The following table demonstrates the potential outcomes from an NCQA accreditation survey.

Accreditation Survey Key:		
★★★★	Excellent	Service and clinical quality meets or exceeds rigorous requirements for consumer protection and quality improvement. HEDIS® results are in the highest range of national performance.
★★★	Commendable	Organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement.
★★	Accredited	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take further action to achieve a higher accreditation status.
★	Provisional	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take significant action to achieve a higher accreditation status.
(No stars)	Denied	NCQA denies accreditation to organizations whose programs for service and clinical quality did not meet NCQA requirements during the accreditation survey.

Managed Care Organization (MCO) Quality Monitoring – CAHPS® Member Satisfaction Surveys: To maintain their accreditation by the National Committee for Quality Assurance (NCQA), Rhode Island’s Medicaid-participating Health Plan must conduct an annual member satisfaction survey, using the *Consumer Assessment of Healthcare Providers and Systems (CAHPS®)* methodology. The NCQA uses the CAHPS® survey, which is endorsed by the National Quality Forum (NQF), to assess member satisfaction experience with care as a part of the annual HEDIS® measurement process.

CAHPS® results must be collected and reported separately for populations covered by commercial insurance and Medicaid. Both of Rhode Island’s Medicaid-participating MCOs engage NCQA-certified external, independent survey vendors to conduct the CAHPS® Health

Plan Survey 4.0 using the *Adult Medicaid Questionnaire*. The CAHPS® Health Plan Survey measures managed care enrollees' satisfaction with:

- Getting needed care
- Getting care quickly
- How well doctors communicate
- Health plan customer service
- Shared decision-making
- Rating of all health care
- Rating of personal doctor
- Rating of specialist

Findings from the Health Plans' annual member satisfaction surveys are analyzed by RI Medicaid as part of its programmatic oversight and by the State's External Quality Review Organization. On an annual basis, each Health Plan presents the findings from its CAHPS® member satisfaction survey process to its own internal Quality Improvement Committee and to Rhode Island Medicaid's Oversight and Management Team. Use of the findings from its annual CAHPS® survey is an integral component of a Health Plan's annual quality improvement plan.

Managed Care Organization (MCO) Quality Monitoring – HEDIS® Quality Measures: Because NCQA Accreditation is required for participation in Rhode Island's Medicaid managed care program and HEDIS® performance is an NCQA accreditation domain, both of the State's Medicaid-participating Health Plans report their HEDIS® findings annually to the NCQA and to the State. Rhode Island Medicaid, in turn, provides the Health Plans' final audited HEDIS® results and the reports from the NCQA-certified HEDIS® Compliance Auditors to the State's External Quality Review Organization (IPRO, Incorporated) for inclusion in the Federally-mandated annual External Quality Review (EQR) process.

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of health care performance measures in the United States. The HEDIS® methodology was devised in the late 1980s and its oversight was entrusted to the National Committee for Quality Assurance (NCQA) in response to a broad-based demand for standardized, objective information about the performance of a wide range of Managed Care Organizations (including Health Plans, Preferred Provider Organizations, Point of Service Plans, Accountable Health Organizations, and Management Behavioral Health Organizations).

The reporting specifications for HEDIS® measures are produced annually by stakeholders who are external and internal to the NCQA. The NCQA's Committee on Performance Measurement (CPM) oversees the evolution of the specifications for the collection of HEDIS® measures. The CPM is a diverse, multi-disciplinary group that reflects the interests of:

- Consumers
- Health care purchasers
- Health care providers
- Health policymakers

The NCQA's Committee on Performance Measurement includes representation from the following groups:

- The American Academy of Family Physicians (AAFP)
- The Centers for Medicare and Medicaid Services (CMS)
- The American Association of Retired Persons (AARP)
- The RAND Corporation
- The American Board of Medical Specialties
- The Center for Medical Consumers
- The U.S. Office of Personnel Management
- Pathways to Excellence
- The National Business Group on Health

In the most recent set of HEDIS® specifications (HEDIS® 2013), there are over eighty (80) HEDIS® measures which span five (5) domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Relative Resource Use
- Health Plan Descriptive Information

HEDIS® results must be collected and reported separately for populations covered by commercial insurance, Medicaid, and Medicare. The HEDIS Compliance Audit™ is a process that occurs concurrently with HEDIS® Data Collection. These annual Compliance Audits result in audited rates at the individual HEDIS® measure level and indicate if the measures can be publicly reported. All measures selected for public reporting must have a final, audited result. The Compliance Audit™ is required for MCOs that seek to either receive or maintain NCQA accreditation or for reporting by the NCQA in Quality Compass®.

As noted previously, the State's EQR analyzes the Health Plans' HEDIS® final, audited results as well as the reports from the NCQA-certified HEDIS® Compliance Auditors. These findings are trended by the EQRO over a three-year period. Please refer to the preceding discussion about the State's Performance Goal Program, which offers information about how HEDIS® measures are integrated into the State's oversight and monitoring of the Health Plans' performance.

Medicaid Expansion

As indicated in Section IV – Delivery System and Payment Rates for Services, Rhode Island seeks to build on its successful experience in serving Medicaid enrollees who are enrolled in its capitated managed care (RIte Care and Rhody Health Partners). As the State moved forward with Medicaid expansion as part of the Affordable Care Act, it anticipates enrolling all new Medicaid eligible adults into current capitated managed care such as RIte Care. The current Quality

Strategy and specific quality assessment processes, performance indicators, and improvement strategies would encompass this new population. In addition, Rhode Island Medicaid was recently awarded an Adult Medicaid Quality Grant, providing the State with an opportunity to develop and evaluate methods for collecting and reporting the Initial Core Set of Health Care Quality Measures for Adults.

Health Homes

Under the Affordable Care Act (ACA), the State has implemented a Health Homes program providing the opportunity to ensure that the State meets a primary goal of the 1115 Waiver, to provide more cost-effective services through a person-centered system of integrated care and Health Homes to Rhode Islanders. As indicated previously, RI has established a robust Quality Assurance and Improvement Program (QAIP) under the 1115 Waiver that has been recognized by CMS for its excellence. Since its inception on October 1, 2011, the Health Home initiative was integrated into this QAIP.

In addition, the State has developed Health Home specific quality measures to monitor and ensure the quality and safety of care and services provided, assure compliance with program requirements, and identify areas of improvement. The latter is accomplished through Health Home reporting, on-site visits and by reviewing claims data from the MMIS, Encounter Data, and CEDARR Case Management systems.

These State developed quality measures include traditional utilization metrics such as decrease in Emergency Room utilization for Ambulatory Care Sensitive (ACS) Conditions, reduction in hospital re-admissions, and nursing home admissions. Measures to assess clinical outcomes, experience of care and quality of life for the Health Home services (e.g. comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services) are also included. In addition, Health Homes are working with Managed Care Organizations to coordinate care and services, including the enhancement of data sharing for quality purposes.

On January 15, 2013, CMS released a Guidance regarding Health Home Core Quality Measures. CMS shared these measures in advance of rulemaking and as such States are not required to utilize these measures until the regulations are promulgated. As this program moves forward, the receipt of these recommended core measures in advance is helpful to the current management of the Health Homes program and to local providers who will be required to report health care quality measures in order to receive payment.

The recommended Health Home core quality measures are aligned with the Initial Core Set of Quality Measures for Adults and the Department of Health and Human Services' (HHS) National Strategy for Quality Improvement in Health Care. As the implementation of the Health Home Quality Strategy moves forward, next steps include the presentation and discussion of the overall Evaluation Design, both CMS Core Quality Measures and the State developed measures, to various EOHHS committees, including the Global Waiver Quality & Evaluation workgroup and the EOHHS Consumer Advisory Committee.

Integrated Care for Medicare and Medicaid Enrollees

Rhode Island is currently finalizing the procurement for both medical and/or functional services to eligible Medicaid recipients through a capitated managed care contract and an enhanced primary care case management (PCCM) program. The population for inclusion in this model would be all Dual Eligibles who have a level of care determination as the highest, high or preventive levels.

The Managed Long Term Care (capitated model) will contract for all long-term care services and supports and all acute care services paid by Medicaid as wraparound of Medicare coverage. This would include defined requirements for active coordination with Medicare covered services to minimize fragmentation. This could be facilitated where Dual Eligible are currently enrolled in Medicare Advantage plans.

The enhanced PCCM model will seek a bundled service contract to build a Community Health Care Team (CHCT) that would focus on long-term care services and supports. This community based entity must demonstrate expertise and the necessary tools to perform the care/case management, care coordination, transition services, nursing facility inpatient management for non-skilled care, social supports, housing, and transportation supports, and services integration functions in collaboration with the PCCM.

As part of the planning process, a Stakeholder process was implemented to ensure collaboration with key stakeholders, transparency, and community input and guidance. A goal of this process was to solicit recommendations from external Stakeholders for the development of State contract procurement documents. Three workgroups were created one of which focused on Oversight, Monitoring, & Continuous Improvement. The goal of this workgroup was to provide recommendations for determining the appropriate quality performance measures for individuals enrolled in the program; to monitor outcomes; and develop a process for oversight, evaluation, and continuous quality improvement. The workgroup met three times over a seven-week period. In order to have well-rounded input, State representatives as well as topic experts from the community were selected as workgroup facilitators. Based upon input from the Workgroup meetings, domains and potential measures were identified and reorganized into the following 6 areas:

1. Utilization
2. Clinical Care (Preventative, Chronic Care, Behavioral, Substance abuse treatment etc...)
3. Access to Care
4. Person-Centered Care
5. Quality of Life (includes Poverty Issues)
6. Care Management

The measures were inclusive of both process and outcome measures. The Stakeholder process and the measures identified for consideration informed the measurement framework drafted for inclusion in the final Model Contract. This measurement set was vetted internally and was aligned to the greatest extent with national measurement sets such as the Initial Core Set of Medicaid Adult Quality Measures and the National Quality Forum, Measure Application

Partnership (MAP). The MAP is a public-private partnership convened by the National Quality Forum (NQF) which was created to provide input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment program. MAP has an array of workgroups, including a work group dedicated to the development of quality measures specific to Dual Eligible beneficiaries. The Model Contract is currently being finalized and is yet to be submitted formally to CMS. RI Medicaid anticipates that CMS will offer further guidance on the proposed quality measurement framework for Rhode Island's Integrated Care initiative in an effort to align with initiatives being implemented by other States.