



**PROPOSED EVALUATION DESIGN FOR SECTION 1115  
WAIVER NO. 11-W-00242/1**

**DRAFT**

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WAIVER NO. 11-W-00242/1**

It is an honor to present the Centers for Medicare and Medicaid Services (CMS) with the following proposed Evaluation Design for the State of Rhode Island's *Global Consumer Choice Section 1115 Demonstration Waiver*. The State looks forward to partnering with CMS over the five-year approval period for the Demonstration Waiver, as Rhode Island administers its Medicaid program under a single Section 1115(a) Demonstration.

The overarching goal of Rhode Island's Global Consumer Choice Waiver is to make the right services available to Medicaid beneficiaries at the right time and in the right setting. Under the Global Waiver, the State's person-centered approach to service design and delivery is being extended to every Medicaid beneficiary, irrespective of age, care needs, or basis of eligibility. Accordingly, all Medicaid-funded services on the continuum of care are now organized, financed, and delivered through a single waiver. As CMS' Acting Administrator noted in January of 2009, the impact of Rhode Island's Demonstration may serve as a best practice for other states with similar demographics.

In recognition of the unique nature of Rhode Island's Global Consumer Choice Waiver, the proposed Evaluation Design includes detailed background on the Demonstration for CMS and other potential policymaking audiences. Therefore, salient background is offered in the first three chapters of the proposed Evaluation Design. Chapter 1 summarizes the Global Waiver's enabling legislation enacted by the Rhode Island General Assembly and describes the Demonstration's eligible populations, its benefits, and delivery systems. Further relevant background is provided in Chapter II, which offers the reader a summary of the Waiver's evaluation design requirements, as outlined by CMS in its Special Terms and Conditions for the Demonstration. Chapter III gives a synopsis of the Global Waiver's three major goals and supporting objectives.

The Demonstration's evaluation design itself is addressed in detail in Chapter IV. Narrative text delineates Rhode Island's proposed methodology for evaluating each of the major components of the Demonstration:

- Long-term Care
- RIte Care
- RIte Share
- Extended Family Planning
- Focused Evaluations of Expansion Groups

As noted previously, the Demonstration is far-reaching in its breadth. Therefore, in addition to presenting a narrative description of the Demonstration's proposed Evaluation Design, we have organized its framework in a tabular manner in Appendix A. For each component of the Waiver, Appendix A delineates the relevant goals, objectives, evaluation questions, illustrative measures, and data sources.

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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 the 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 will also be required.

## **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

As indicated above, the State implemented the core components of the Demonstration on July 1, 2009. A few remaining portions will be phased in over time; these yet to be implemented components are discussed in Chapter IV.

## 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 now operates its 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).<sup>1</sup> 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 – are now 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 are 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:

- o Changes to the instruments used to determine the level of care
- o Changes to the Assessment and Coordination Organization Structure
- o Changes to general operating procedures
- o Changes to provider network methodologies (provider enrollment procedures, but not delivery system changes)
- o Changes to prior authorization procedures
- o 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.

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<sup>1</sup> Administrative expenses and phased-Medicare Part D contributions are also excluded from the five-year aggregate cap on Federal funds.

- Modifying an HCBS service definition to adopt the core definition.
- 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 result 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 Changes 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 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 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 accomplishment the above three kinds of changes.

### **1.3 ELIGIBLE POPULATIONS**

The State must maintain eligibility of all optional populations that were covered under the Rhode Island Medicaid State Plan as of November 1, 2008 except to the extent the Demonstration expressly permits changes in eligibility methods and standards. Table 1 below shows all of the eligibility groups covered under this Demonstration.

**Table 1**

**Eligibility Groups Covered Under the Demonstration**

**Categorically Needy Medicaid Eligibility Groups**

**Mandatory Categorically Needy Coverage Groups**

<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>	<b>Expenditure and CMS-64 Eligibility Group Reporting</b>
§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	<i>Income:</i> Up to 133 percent of	Budget Population 3

<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>	<b>Expenditure and CMS-64 Eligibility Group Reporting</b>
§1902(a)(10)(A)(i)(VI)	FPL <i>Resource:</i> No resource test	RItE Care
Poverty level children under age 19, born after September 30, 1983 (or, at State option, after any earlier date) §1902(a)(10)(A)(i)(VII)	<i>Income:</i> Up to 100 percent of FPL <i>Resource:</i> No resource test	Budget Population 3 RItE Care
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	<i>Income:</i> 100% SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL

<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>	<b>Expenditure and CMS-64 Eligibility Group Reporting</b>
42 CFR 435.122		
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**

<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>	<b>Expenditure and CMS-64 Eligibility Group Reporting</b>
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 <sup>2</sup> §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	<i>Income:</i> 100% SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL

<sup>2</sup>The 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 ICF/MRs.  
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<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>	<b>Expenditure and CMS-64 Eligibility Group Reporting</b>
§ 1902(a)(10)(A)(ii)(I) Individuals who would have been eligible for SSI or State supplement if not in a medical institution	<i>Income:</i> 100% SSI <i>Resource:</i> \$2,000 individual \$3,000 couple	Budget Population 1 ABD no TPL
§ 1902(a)(10)(A)(ii)(IV) 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	<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
§ 1902(a)(10)(A)(ii)(V) Aged or disabled individuals whose SSI income does not exceed 100% of FPL	<i>Income:</i> =< 100 percent FPL <i>Resource:</i> \$4,000 individual \$6,000 couple	Budget Population 1 ABD no TPL
§ 1902(a)(10)(A)(ii)(X) Individuals receiving only an optional State supplement payment which may be more restrictive than the criteria for an optional State supplement under Title XVI	<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
§ 1902(a)(10)(A)(ii)(XI) BBA working disabled group: Working disabled individuals who buy in to Medicaid	<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
§ 1902(a)(10)(A)(ii)(XIII) Uninsured women, under 65, who are screened for breast or cervical cancer under CDC program and not eligible for Medicaid		Budget Population 14 BCCTP
§ 1902(a)(10)(A)(ii)(XVIII) 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	<i>Income:</i> 300 percent of SSI Federal benefit level <i>Resource:</i> \$2,000	Budget Population 4 CSHCN
§ 1902(e)(3) Presumptive eligibility for women who are screened for breast or cervical cancer under CDC program		Budget Population 14 BCCTP
§ 1920B		

## MEDICALLY NEEDEY MEDICAID ELIGIBILITY GROUPS

### Mandatory Medically Needy Coverage Groups

Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria	Expenditure and CMS-64 Eligibility Group Reporting
Individuals under 18 who would be mandatorily categorically eligible except for income and resources §1902(a)(10)(C)(ii)(I)	<i>Income:</i> 133 <sup>1</sup> / <sub>3</sub> 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 <sup>1</sup> / <sub>3</sub> 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 <sup>1</sup> / <sub>3</sub> 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 <sup>1</sup> / <sub>3</sub> 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) <sup>3</sup>	<i>Income:</i> 133 <sup>1</sup> / <sub>3</sub> 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 <sup>1</sup> / <sub>3</sub> 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

<sup>3</sup> The 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 ICF/MRs.

**Optional Medically Needy Coverage Groups**

<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>	<b>Expenditure and CMS-64 Eligibility Group Reporting</b>
Aged individuals who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(iii)	<i>Income:</i> 133 <sup>1</sup> / <sub>3</sub> 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 <sup>1</sup> / <sub>3</sub> 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 <sup>1</sup> / <sub>3</sub> 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

## ELIGIBILITY GROUPS UNDER THE DEMONSTRATION

### Groups That Could Be Covered Under the State Plan but Gain Eligibility through Section 1115 Demonstration

Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria	Expenditure and CMS-64 Eligibility Group Reporting
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

### Expansion Groups under Section 1115 Demonstration

Medicaid Eligibility Groups	Income and Resource Standards and/or Other Qualifying Criteria	Expenditure and CMS-64 Eligibility Group Reporting
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 who 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> No resource test	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% 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:</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	Budget Population 11 217 & PACE like Categorically needy Highest

<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>	<b>Expenditure and CMS-64 Eligibility Group Reporting</b>
	regulations and section 1924 of the Social Security Act, if the State had 1915(c) waiver programs.	
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	<i>Income:</i> 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	<i>Income:</i> 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 inpatient hospitalization	<i>Income:</i> up to 250% FPL <i>Resource:</i>	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	<i>Income:</i> up to 300% of SSI for child  <i>Resource:</i>	Budget Population 17 Youth at risk for Medicaid
HIV Positive individuals who are otherwise ineligible for Medicaid	<i>Income:</i> 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.	<i>Income:</i> up to 200% FPL <i>Resource:</i>	Budget Population 19 Non-working disabled adults

## 1.4 BENEFITS

Paragraph 27 of the STCs provides the following with respect to benefits under the Demonstration:

- a) **RItE Care.** Benefits are the full scope of benefits set forth in the approved State plan as of November 1, 2008, unless specified in this document. 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. All benefits that are available to RItE Care enrollees under this Demonstration are listed in Attachment A. The State has the flexibility to provide customized benefit packages to beneficiaries based on medical need, and the amount duration and scope of all covered services may vary to reflect the needs of the populations served.
- b) **Extended Family Planning Program.** Family planning services are provided for a maximum period of 24 months to eligible recipients at or below 200 percent of the FPL who lose Medicaid eligibility at the conclusion of their 60-day postpartum period. See Section 4.4 for more detailed requirements.
- c) **Long-Term Care and HCBS.** The State has the flexibility to provide customized benefit packages to beneficiaries that include long-term care and home and community based services based on medical necessity and an individual's plan of care. In addition the State will provide all individuals who meet the highest, high or preventive level of care criteria with access to HCBS, as described in paragraph 28, subject to any waiting list as described in paragraph 29. The service definitions are included in Attachment B of this document. The amount, duration and scope of all covered services may vary to reflect the needs of the individual in accordance with his or her plan of care. More detailed requirements are provided in this section in paragraphs 28-30.

Paragraphs 28 to 30 of the STCs provide the following specifically regarding Long-Term Care and HCBS:

**28. Long-Term Care and HCBS.** The long-term care component of the demonstration will provide institutional and home and community-based long term care services including an option for self direction to individuals eligible as aged, blind or disabled (ABD) under the Medicaid State Plan. Primary care for this population will be provided through mandatory care management programs, which include Connect Care Choice and Rhody Health Partners. Based on a level of care determination individuals eligible as ABD under the Medicaid State Plan will fall into the following groups: 1) highest 2) high and 3) preventive.

- a) *Highest level of care.* Individuals who are determined based on medical need to require the institutional level of care will receive services through nursing homes, long term care hospitals or intermediate care facilities for the mentally retarded (ICF/MR). Beneficiaries meeting this level of care will have the

option to choose community-based care including core and preventive services as defined in Attachment B.

- b) *High level of care.* Individuals who are determined based on medical need to benefit from either the institutional level of care or a significant level of home- and community-based services will have access to community based core and preventive services as defined in Attachment B.
- c) *Preventive level of care.* Individuals who do not presently need an institutional level of care will have access to services targeted at preventing admission, re-admissions or reducing lengths of stay in an institution. These beneficiaries will receive preventive services as defined in Attachment B.
- d) The State will include the services of up to nine of Rhode Island's pre-demonstrational 1915(c) HCBS waivers into the Demonstration. The existing waivers include 0040.90.R5 (Aged and Disabled), 0176.90.R3 (Elderly), 0335.90.R1 (Assisted Living), 0379.90.03 (Habilitation), 0041-IP.03 (Personal Choice), 0462 (Respite for Children-Hospital), 0463 (Respite for Children-ICF/MR), 0466 (Children with Mental Illness), 0162.90.R3 (MR/DD).
- e) Primary and acute care services for Medicaid ABD eligible individuals meeting the highest, high or preventive level of care may be provided through Primary Care Case Management or Rhody Health Partners or Connect Care Choice plans or other managed fee-for-service (FFS). Individuals who are dually eligible for Medicare and Medicaid will receive primary and acute care services through Medicare FFS, a Medicare Advantage Plan or through the Program of All Inclusive Care for the Elderly (PACE). This STC does not preclude the State from entering into other contract arrangements with entities that can provide these services.

**29. Waiting List for HCBS.** Should a waiting list for long-term care services develop, the State must provide services for individuals classified in higher levels of care categories before providing services to individuals classified in lower categories. Specifically, participants receiving services must continue to receive services unless their condition improves and they move to a lower level of care category. Also, participants and applicants in the highest category are entitled to services and must not be put on a waiting list for institutional services. (If a community placement is not initially available, they may be put on a wait list for transition to the community.) Finally, applicants for the high group must receive services prior to applicants in the Preventive category.

**30. Long-Term Care Enrollment.** For those participants residing in an institution at the point of implementation of the Demonstration, the State must apply pre-demonstration level of care criteria to those individuals unless the participant transitions to the community because he or she (a) improves to a level where they would no longer meet the pre-demonstration institutional level of care, or (b) the individual chooses community care over institutional care. Once that participant is residing in the community, all future level of care redeterminations will be based on the new level of care criteria established for the purposes of this Demonstration.

A key element of the Demonstration is to use Costs Not Otherwise Matchable (CNOM) authority to provide limited benefit packages to groups who would not otherwise be eligible for Medicaid in the State in order to prevent them from becoming Medicaid-eligible and, thus, eligible for the full Medicaid benefit package. CNOM authority is also being used for administrative flexibility under the Demonstration. Table 2 lists the CNOM eligibility and services groups which are discussed further in Chapter IV, Section 4.5.

**Table 2**

**CNOM Eligibility and Service Groups**

<b>CNOM Eligibility Group</b>	<b>Demonstration Budget Population Group</b>
Children and families in managed care enrolled in RItE Care Medicaid parents have behavioral health conditions that result in their children being placed in temporary State custody	Budget Population 8
Children with special health care needs who are 21 and under who would otherwise be placed in voluntary State custody-residential diversion	Budget Population 9 & Budget Services Group 4
Elders at risk of LTC	Budget Population 10
Adults with disabilities at risk for LTC who would otherwise not eligible for Medicaid	Budget Population 15
Uninsured adults with mental illness	Budget Population 16
Children at risk for Medicaid and/or institutional care	Budget Population 17
HIV positive individuals who are otherwise not eligible for Medicaid	Budget Population 18

## 1.5 DELIVERY SYSTEMS

Paragraphs 34 to 36 of the STCs provide the following with respect to the delivery systems under the Demonstration:

**34. Assessment and Coordination Organization Process:** Access to institutional and community-based supports and services will be through the Assessment and Coordination Organization (ACO). The purpose of the ACO is to streamline the intake and assessment processes and provide beneficiaries and their families with clear, concise, and accurate information about their care options. The ACO is described more fully in Attachment D.

**35. Long-Term Care Services:** Institutional and community-based long-term care services will be delivered through one of the following delivery systems:

Fee-for-service: Beneficiaries will be able to access long-term care services in the same way that services are accessed today, through a fee-for-service system. Under this system, a beneficiary can choose the Medicaid participating agency or provider who will deliver the service(s). In turn for those services requiring authorization or that are “out-of-plan”, the agency/provider bills the Medicaid agency for services authorized by the ACO and/or the health plan or PCCM network.

Self-direction: Beneficiaries and their families will also have the option to purchase HCBS waiver like services through a self-direction service delivery system. Under this option, beneficiaries will work with the ACO to develop a budget amount for services needed. The beneficiary, with the support of a fiscal intermediary, will then be able to purchase services directly. This option is based on experience from Rhode Island’s 1915(c) Cash and Counseling Waiver (*RI Personal Choice*), 1915(c) Developmental Disabilities Waiver, and Personal Assistance Service and Supports program. Self-Direction is fully described in the Self-Direction Operations Section of the STCs.

**36. Primary and Acute Care Services:** Primary and acute care services will be delivered through the following systems:

Managed Care Organizations: *RIte Care, RIte Share, and Rhody Health Partners; PACE*

Primary Care Case Management Program: *Connect Care Choice*

Pre-paid Ambulatory Health Plans: *RIte Smiles*

Fee-for-service

The STCs also provide that enrollees’ freedom of choice of providers under the Demonstration will be limited and that State may employ selective contracting.

## CHAPTER II

### DEMONSTRATION EVALUATION DESIGN REQUIREMENTS

Paragraph 95 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<sup>4</sup>. 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;

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<sup>4</sup> On 06/22/2009, CMS gave its authorization for Rhode Island to submit the Demonstration's draft Evaluation Design on 07/20/2009.

- 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 remainder of this document addresses these requirements. However, it should be noted that the requirements in d) above are not fully aligned with the CNOM budget population and services groups in Table 2 or with other important components of the Demonstration. This will be addressed in subsequent chapters of the evaluation design document.

It should also be noted that Paragraph 99 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.

Therefore, this evaluation design document will not address the home- and community-based services system except to the extent that it is tied to long-term care reform or CNOM groups

## **CHAPTER III**

### **GOALS AND OBJECTIVES FOR THE DEMONSTRATION**

Given that this Demonstration encompasses virtually the entire State's Medicaid program, it is useful to distill what the State is trying to accomplish in order to place its evaluation in an appropriate context. First and foremost, the State wants to contain the overall costs of its Medicaid program. In order to accomplish this, the State intends to:

- Reform the long-term care component of the Rhode Island Medicaid Program
- Use CNOM authority to prevent or delay growth in the population eligible for Medicaid
- Use administrative flexibility so that the State may operate its Medicaid program more efficiently, through the application of selective contracting strategies, care management systems, and links to "medical homes"

In the following chapter, Rhode Island presents its proposed Evaluation Design for the Demonstration, using a narrative format. Goals, objectives, and a series of evaluation questions are proposed to address each of the major components of the Global Consumer Choice Waiver:

- Long-term Care (Section 4.1)
- RItE Care (Section 4.2)
- RItE Share (Section 4.3)
- Extended Family Planning (Section 4.4)
- Focused Evaluation of Expansion Group (Section 4.5)

## CHAPTER IV

### DEMONSTRATION EVALUATION DESIGN

The major components of Rhode Island's Global Consumer Choice Compact were launched on July 1, 2009. However, there are several elements still in a state of active development which are not yet operational. Therefore, the evaluation design will be iterative. As the remaining operational components of the Demonstration are finalized and implemented, the relevant evaluation design will be updated and submitted to CMS.

Due to the scope of the Global Choice Compact Rhode Island's evaluation is organized both a narrative and tabular manner. Narrative text fully addresses the State's plan for evaluating the major components of the Global Waiver: Long-term Care, RItE Care, RItE Share, Extended Family Planning and Focused Evaluations of Expansion Groups. The evaluation framework is also mapped in a tabular manner in Appendix A (Evaluation Design Framework for the Global Choice Waiver).

Appendix A presents a concise overview of the evaluation design for this demonstration. For each component of the Demonstration for which a specific evaluation design is required, the Appendix A shows:

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

As shown in Appendix A, multiple data sources may be analyzed in order to answer some of the evaluation questions. Appendix A also presents illustrative measures. Illustrative measures are delineated and reflect the depth and breadth of the measures which will be used in the evaluation of the Demonstration.

The following narratives describe the State's plan for evaluating the major components of the Global Waiver:

- Long-term Care (Section 4.1)
- RItE Care (Section 4.2)
- RItE Share (Section 4.3)
- Extended Family Planning (Section 4.4)
- Focused Evaluations of Expansion Groups (Section 4.5)

#### 4.1 EVALUATION PLAN – LONG-TERM CARE

The over-arching goal of Rhode Island’s Global Consumer Choice Compact is to ensure that every Medicaid long-term care (LTC) beneficiary receives the appropriate services, at the appropriate time, and in the most appropriate and least restrictive setting. To achieve this goal for LTC services, the Global Consumer Choice Compact provides Rhode Island with the authority to merge its existing section 1915 (c) home- and community based service waivers (HCBS) into its newly approved section 1115 (a) Global Waiver, effective on July 1, 2009. The transition in authority permits Rhode Island to undertake the following.

- Implement new needs-based levels of care
- Expand the number of individuals that can access long-term care services
- Increase the availability of home- and community-based services

In Chapter III, Rhode Island has set forth a series of program goals and objectives to support its primary goal to undertake measurable reform of the State’s Medicaid LTC program. Flowing from these program objectives are a series of evaluation questions and related measures. As noted previously, the State’s Global Consumer Choice Compact is, by design, an innovative and dynamic work in progress.

**LTC Goal 4.1:** To undertake measurable reform of Rhode Island Medicaid’s long-term care program. **LTC Objective 4.1.1:** To rebalance the State’s existing long-term care system with home- and community-based services.

To achieve the reform of Rhode Island’s long-term care (LTC) system, the Global Consumer Choice Compact Waiver allows beneficiaries to obtain the Medicaid services that they need in the most appropriate and least restrictive setting. The State has defined Medicaid funded LTC services as those which are “... designed to help people who have disabilities or chronic care needs to optimize their health and retain their independence”. Services may be short or long-term in duration.

The types of LTC services have been organized into two (2) major categories:

- Facility-based – those which are those provided in a licensed health care facility, including the following:
  - Nursing facilities
  - Intermediate Care Facility for the Mentally Retarded (ICF/MR)
- Home- and Community-based – those which are rendered outside a long-term care (LTC) facility, in any of the following settings:
  - The beneficiary’s home (or the home of a beneficiary’s family member)
  - Assisted living
  - Shared living

A series of evaluation questions and performance measures have been posed to determine the utilization of LTC facility-based services in Rhode Island prior to and following the implementation of Rhode Island’s Global Consumer Choice Compact on 07/01/2009.

Likewise, Rhode Island will monitor its annual expenditures for these services in comparison to related costs sustained in State Fiscal Year (SFY) 2008 and SFY 2009.

Over the course of the Global Waiver, the State will analyze whether the utilization distribution of Medicaid aged and disabled beneficiaries receiving care in LTC facilities has shifted, reflecting an increase in favor of home and community-based care. Rhode Island will seek to determine whether the costs of providing facility-based LTC to Medicaid aged and disabled beneficiaries have been controlled.

The following series of questions focus upon care provided within LTC facilities.

Evaluation Question LTC 4.1.1.1: Over the course of the Global Waiver, has there been a change in the number of admissions to LTC facilities (nursing facilities and ICF/MRs) paid by Medicaid?

Measure: The State will quantify the number of admissions to LTC facilities paid by Medicaid. Rhode Island will determine whether over the course of the Global Waiver there has been a reduction in the number of admissions to LTC facilities paid by Medicaid.

Evaluation Question LTC 4.1.1.2: Over the course of the Global Waiver, has there been a change in the number and percentage of Medicaid aged and disabled beneficiaries who were discharged from LTC facilities to home or community-based settings?

Measure: The State will quantify the number and percentage of beneficiaries who were discharged from LTC facilities to home or community-based settings. Rhode Island will determine whether over the course of the Global Waiver there has been a change in the number and percentage of beneficiaries discharged from LTC facilities to home or community-based settings.

Evaluation Question LTC 4.1.1.3: Over the course of the Global Waiver, has there been a change in the average length of stay (ALOS) in LTC facilities (nursing facilities and ICF/MRs) by Medicaid aged and disabled beneficiaries?

Measure: The State will quantify the ALOS in LTC facilities by Medicaid aged and disabled beneficiaries. Rhode Island will determine whether over the course of the Global Waiver there has been a change in the ALOS in LTC facilities by Medicaid aged and disabled beneficiaries.

Evaluation Question LTC 4.1.1.4: Over the course of the Global Waiver, has the average daily census in LTC facilities (nursing facilities and ICF/MRs) changed for Medicaid aged and disabled beneficiaries?

Measure: The State will quantify the average daily census for care provided in LTC facilities to Medicaid aged and disabled beneficiaries. Rhode Island will determine whether over the course of the Global Waiver there has been a change in the average daily census in LTC facilities for Medicaid aged and disabled beneficiaries.

Evaluation Question LTC 4.1.1.5: Has the cost of care provided to Medicaid aged and disabled beneficiaries in LTC facilities been controlled over time?

Measure: The State will quantify Medicaid expenditures for aged and disabled beneficiaries in LTC facilities. Rhode Island will determine whether over the course of the Global Waiver there has been a change in Medicaid expenditures for aged and disabled beneficiaries in LTC facilities.

**LTC Goal 4.1:** To undertake measurable reform of Rhode Island Medicaid's long-term care (LTC) program. **LTC Objective 4.1.2:** To increase the utilization of home- and community-based services in Rhode Island.

The Global Waiver authorizes the State to offer an array of home- and community-based services to beneficiaries as an alternative in order to avoid institutionalization. Home and community-based LTC services and supports are adjuncts to the services and benefits otherwise provided under the Medicaid program.

Therefore, a series of evaluation questions have been posed to determine the utilization of home- and community-based services in Rhode Island prior to and following the implementation of Rhode Island's Global Consumer Choice Compact on 07/01/2009. Trends in the utilization of home- and community-based services and their associated expenditures will be monitored over the course of the Global Waiver.

Evaluation Question LTC 4.1.2.1: Over the course of the Global Waiver, has there been a change in the volume of beneficiaries receiving one or more core home- and community-based services, such as assisted living, private duty nursing, or shared living?

Measure: The State will quantify the volume of beneficiaries receiving one or more types of core home- and community-based services. Rhode Island will determine whether over the course of the Global Waiver there has been a change in the number of beneficiaries receiving one or more types of core home- and community-based services.

Evaluation Question LTC 4.1.2.2: Over the course of the Global Waiver, has there been a change in the utilization of core home- and community-based services?

Measure: The State will quantify the utilization of core home- and community-based services. Rhode Island will determine whether over the course of the Global Waiver there has been a change in the number of beneficiaries receiving one or more types of core home- and community-based services.

Evaluation Question LTC 4.1.2.3: Has the utilization distribution of Medicaid aged and disabled beneficiaries shifted between LTC facilities and home- and community-based services?

Measure: The State will stratify Medicaid utilization data to differentiate care rendered in LTC facilities versus home and community-based care. Rhode Island will determine whether over the course of the Global Waiver there has been a change in the distribution of LTC utilization.

Evaluation Question LTC 4.1.2.4: Has the cost distribution for Medicaid aged and disabled beneficiaries shifted between LTC facilities and home- and community-based services?

Measure: The State will stratify Medicaid expenditures by setting of care (i.e., for LTC facilities versus home and community-based care) for the program's aged and disabled

beneficiaries. Rhode Island will determine whether over the course of the Global Waiver the distribution of costs has shifted between facility-based and home and community-based LTC settings.

**LTC Goal 4.1:** To undertake measurable reform of Rhode Island Medicaid's long-term care program. **LTC Objective 4.1.3:** To modify the State's income and resource eligibility requirements for Medicaid-funded long-term care services.

To qualify for Medicaid-funded long-term care (LTC) under the Global Waiver, an individual must meet the general and financial requirements as well as certain clinical eligibility criteria. Under the Global Consumer Choice Compact, Rhode Island has been given the authority to change its prior financial eligibility rules for LTC services in order to:

- Remove any financial incentive to choose an institution rather than home or community-based care
- Facilitate a beneficiary's remaining in the community
- Ensure the uniform application of eligibility rules across population groups

Effective on 07/01/2009, Rhode Island instituted spousal impoverishment rules for individuals who are medically needy or in a special income-level group<sup>5</sup> whose level of care determination documents needs which have been categorized as meeting either the State's highest or high level and who choose to remain in the community. Spousal impoverishment rules require that States protect the resources and income of community-dwelling spouses.

In some instances, spousal impoverishment rules allow the spouse of a beneficiary to maintain more of the couple's resources and his or her income. Therefore, the State believes that more individuals will choose to remain in the community, thereby delaying their entry into institutional settings of care, over a longer period of time.

Likewise, for some beneficiaries, these changes may result in their remaining in home or community-based settings for the remainder of their lives. Rhode Island anticipates that the fiscal impact of the establishment of spousal impoverishment rules for community-dwelling (i.e., non-institutionalized) individuals who are either medically needy or in a special income-level group who present with a level of care meeting either the State's highest or high level will result in a moderate cost savings.

One facet of the State's modified approach to determining financial eligibility for LTC services will not be implemented on 07/01/2009, due to Rhode Island's budgetary constraints and the need for further analysis. This still-to-be-finalized component deals with the post-eligibility treatment of income and maintenance needs allowance (PETI) process, which occurs *after* an individual has been determined eligible for Medicaid funded long-term care services based upon medically needy status. The PETI process does not apply to Medicaid beneficiaries who are categorically eligible.

One of the relevant PETI allowances, which is included in the calculation of a beneficiary's income, is the Maintenance Needs Allowance (MNA). This allowance is defined as the

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<sup>5</sup> These special groups are Budget Population Groups 11, 12, & 13. *Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration, January 2009 – December 2013*, Centers for Medicare and Medicaid Services (pgs. 19 & 20).

amount of income from which the beneficiary will provide for his/her daily living expenses (e.g., rent, food, et cetera). In Rhode Island, the current MNA is \$886.67 per month. Rhode Island will, at a later date, seek to increase the MNA by \$400.00, based upon a reasonable assessment of a beneficiary's needs in the community. The State anticipates that by increasing the MNA, a greater number of beneficiaries will be able to remain in the community rather than transition to a LTC facility.

A series of evaluation questions have been posed to determine the impact of changes to Rhode Island's financial eligibility rules pertaining to LTC services. These questions focus upon the outcome of LTC eligibility determinations, specifically those which are based upon the changes in the financial rules.

Evaluation Question LTC 4.1.3.1: How many Medicaid LTC applicants meet the revised financial eligibility thresholds based upon the State's new spousal impoverishment rules for individuals who are medically needy in a special income-level group (i.e., Budget Population Groups 11, 12, and 13)?

Measure: The State will stratify the outcomes (i.e., approved versus denied) of the State's LTC eligibility determination data based upon the State's new financial eligibility rules pertaining to the community spouse's income. Rhode Island will determine whether over the course of the Global Waiver there has been a change in the number of LTC applicants who meet the financial eligibility threshold.

Evaluation Question LTC 4.1.3.2: How many Medicaid LTC applicants who meet the new financial eligibility thresholds remain in home or community based settings rather than enter a LTC facility?

Measure: The State will quantify how many Medicaid LTC applicants who meet the new financial eligibility thresholds receive core home or community-based care instead of using facility-based LTC. Rhode Island will determine whether over the course of the Global Waiver there has been a shift in the volume of new LTC applicants who receive home- and community-based services.

**LTC Goal 4.2:** To establish an objective, needs-based level of care determination process for Medicaid LTC applicants and beneficiaries. **LTC Objective 4.2.1:** 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.

Under the Global Waiver, the scope of long-term care (LTC) services available to a beneficiary is to be based upon a new process for determining the medical, social, physical, and behavioral health needs of each applicant. The State refers to this level of care determination process as "needs-based". A three-tiered level of care assessment tool has been adopted that draws upon key assessment variables derived from the *Minimum Data Set (MDS) 2.0 for Nursing Home Assessment and Care Screening*.

The scope of services accessible to a beneficiary varies in accordance with individuals' needs and preferences, the availability of services, and the parameters established in the Global Waiver and/or Federal and State regulations, rules, or laws. Rhode Island's LTC level of care

and service option matrix under the Global Waiver is as follows, starting with the highest level of need:

<b>Highest Level of Need</b>	<b>Highest Level of Need</b>	<b>Highest Level of Need</b>
<u>Nursing home level of care:</u> <ul style="list-style-type: none"> <li>○ Access to nursing facilities</li> <li>○ Access to all community-based services</li> </ul>	<u>Hospital level of care:</u> <ul style="list-style-type: none"> <li>○ Access to hospital</li> <li>○ Access to residential treatment centers</li> <li>○ Access to all community-based services</li> </ul>	<u>ICF/MR level of care:</u> <ul style="list-style-type: none"> <li>○ Access to ICF/MR</li> <li>○ Access to all community-based services</li> </ul>
<b>High Level of Need</b>	<b>High Level of Need</b>	<b>High Level of Need</b>
<u>Nursing home level of care:</u> Access to community-based services	<u>Hospital level of care:</u> Access to community-based services	<u>ICF/MR level of care:</u> Access to community-based services
<b>Preventive Level of Need</b>	<b>Preventive Level of Need</b>	<b>Preventive Level of Need</b>
<u>Nursing home level of care:</u> Access to preventive community-based services	<u>Hospital level of care:</u> Access to preventive community-based services	<u>ICF/MR level of care:</u> Access to preventive community-based services

**Evaluation Question LTC 4.2.1.1:** How many new Medicaid LTC applicants meet the State’s level of care categories: highest, high, and preventive? How many new Medicaid LTC applicants do not meet any of the three levels of care?

**Measure:** Over the course of the Global Waiver, the State will quantify the outcome of all new LTC level of care determinations (highest, high, preventive, or level of care criteria not met).

**Evaluation Question LTC 4.2.1.2:** How many new Medicaid LTC applicants whose level of care needs were classified in the highest category received home or community-based services?

**Measure:** Over the course of the Global Waiver, the State will stratify how many new Medicaid LTC applicants whose level of care needs were classified in the highest category received home- or community-based services and how many received care in LTC facilities. Rhode Island will assess whether there has been a trend increase in the number and percentage of new Medicaid LTC applicants, whose level of care need was classified as being in the highest category, who received home- or community-based services.

**Evaluation Question LTC 4.2.1.3:** How many of the State’s current (enrolled prior to 07/01/2009) LTC beneficiaries whose levels of care needs were classified in the highest category at the time of eligibility redetermination received home- or community-based services and how many received care in LTC facilities?

**Measure:** Over the course of the Global Waiver, the State will stratify how many current Medicaid LTC beneficiaries (enrolled prior to 07/01/2009) whose level of care needs were classified in the highest category at the time of eligibility redetermination received home- or

community-based services and how many received ongoing care in LTC facilities. Rhode Island will assess whether there has been a trend increase in the number and percentage of current LTC beneficiaries who received home- or community-based care.

Evaluation Question LTC 4.2.1.4: Over the course of the Global Waiver, how many new Medicaid LTC applicants whose level of care needs were classified as meeting the preventive level of care criteria received preventive-level services<sup>6</sup>.

Measure: The State will quantify the number and percentage of LTC beneficiaries classified as meeting the preventive services level of care criteria who received any preventive care services.

Evaluation Question LTC 4.2.1.5: Over the course of the Global Waiver, has there been a change in the utilization of preventive care services?

Measure: The State will quantify the utilization of preventive care services. Rhode Island will assess whether over the course of the Global Waiver there has been a volume increase in the utilization of preventive care services.

As noted in Chapter I, Rhode Island's Global Choice Consumer Compact Demonstration establishes a new State-Federal compact that provides the State with substantially greater flexibility than is available under existing program guidelines. In exchange for the increased flexibility and the opportunity to invest in Medicaid reform, Rhode Island 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 (PMPM) cost trends.

Federal financial responsibilities will be subject to an aggregate budget ceiling. While Rhode Island will be at risk for caseload and unforeseen cost trends, the State will use a variety of tools to adjust the Demonstration's operations so that the State's financial responsibilities are within its budget targets.

In Chapter III, Rhode Island has set forth a series of program goals and objectives to support its primary goal to undertake measurable reform of the State's Medicaid LTC program. Goal 3 and its associated objectives address the impact of the State's initiatives to control the rate of growth of Medicaid expenditures.

**LTC Goal 4.3:** To limit the rate of growth of the State's Medicaid expenditures.

**LTC Objective 3.1:** To control expenditure growth by implementing the objectives for Goals 1 and 2.

Evaluation Question LTC 4.3.1.1: Have the overall costs of providing Medicaid-covered services to population groups eligible prior to the implementation of the Global Waiver been controlled?

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<sup>6</sup> Four types of services have been designated as "preventive care services": homemaker services; minor home environmental modifications; physical therapy evaluation and pre-surgical physical therapy; and respite services. *Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration, January 2009 – December 2013*, Centers for Medicare and Medicaid Services, pg. 67 and 68.  
*Evaluation Design for Section 1115 Waiver No. 11W-00242-1 (Submitted to CMS on 07/17/2009)*

Measure: Over the course of the Global Waiver, Rhode Island will analyze its total Medicaid expenditures which are subject to the Global Aggregate Cap.

**LTC Goal 4.3:** To limit the rate of growth of the State's Medicaid expenditures.  
**LTC Objective 4.3.2:** To implement selective contracting based upon Rhode Island's purchasing analyses.

Evaluation Question LTC 4.3.2.1: Over the course of the Global Waiver, how many selective contracting strategies were initiated by the State? How many contractors were engaged to provide services?

Measure: The State will delineate how many selective contracting strategies were implemented throughout the course of the Global Waiver by type of service. The number of contractors for each type of service will be identified.

Evaluation Question LTC 4.3.2.2: Over the course of the Global Waiver, has there been a change in the utilization of the services covered as a result of selective contracting arrangements?

Measure: The State will quantify the utilization of services covered by selective contracting arrangements over the course of the Global Waiver.

Evaluation Question LTC 4.3.2.3: Over the course of the Global Waiver, have selective contracting strategies resulted in controlled Medicaid expenditures for the related services?

Measure: The State will compare baseline Medicaid expenditure data for services which have been targeted for selective contracting arrangements to the post-implementation expenditures for these service lines over the course of the Global Waiver.

**LTC Goal 4.3:** To limit the rate of growth of the State's Medicaid expenditures.  
**LTC Objective 4.3.3:** 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.

Please refer to Section 4.5 – Focused Evaluations of Expansion Groups for this discussion.

**LTC Goal 4.3:** To limit the rate of growth of the State's Medicaid expenditures.  
**LTC Objective 4.3.4:** To promote the delivery of case management services for beneficiaries through organized systems of care.

Evaluation Question LTC 4.3.4.1: Over the course of the Global Waiver, how many beneficiaries and what proportion were enrolled in the following organized care management delivery systems:

- Connect Care Choice, Rhode Island's primary care case management (PCCM) system
- Rhody Health Partners, Rhode Island's capitated managed care program for disabled adults

Measure: The State will quantify the number of beneficiaries enrolled in organized care management delivery systems over the course of the Global Waiver. Rhode Island will analyze whether there has been a demonstrable increase in the number and percentage of Medicaid beneficiaries participating in organized care management delivery systems.

Evaluation Question LTC 4.3.4.2: Over the course of the Global Waiver, how many beneficiaries without another primary source of health insurance coverage remained in the Medicaid fee-for-service (FFS) program?

Measure: The State will quantify the number of beneficiaries remaining in the Medicaid for service (FFS) program who lack another primary source of health insurance coverage. Rhode Island will analyze whether there has been a decrease in the number of beneficiaries served in the Medicaid FFS program over the course of the Global Waiver.

## 4.2 EVALUATION PLAN – RITE CARE

As noted in Chapter 1, Rhode Island will operate its entire Medicaid program under a single Section 1115 (a) demonstration project commencing on 07/01/2009 with the exception of disproportionate share hospital (DSH) payments and payments to local education agencies (LEAs). All Medicaid funded services on the continuum of care will be organized, financed, and delivered through the Global Consumer Choice Compact Waiver.

In the previous section of this proposal, Rhode Island described its evaluation strategy for long-term care services. The following narrative provides an overview of the State's strategy to integrate the evaluation plan for its former 1115 Medicaid waiver into the section 1115 (a) Global Waiver. The State was initially granted a section 1115 Medicaid waiver in November of 1993 to develop and implement a mandatory Medicaid managed care demonstration. Under that authority, Rite Care was implemented in August of 1994. As of October 1, 2008, managed care enrollment became mandatory for all Rite Care-eligible Children with Special Health Care Needs (CSHCN) who do not have another source of primary health insurance coverage. The State's section 1115 waiver for Rite Care was renewed successfully for its continuance until the program became integrated into the Global Waiver commencing on 07/01/2009.

The following evaluation plan for Rite Care is based upon the program's previous successful evaluation strategy, which was approved by CMS. It should be noted that Rite Care is singularly recognized for its excellence. For the past four years, all three of the Health Plans participating in Rite Care have been recognized within the "Top Ten" among all Medicaid Plans in the country as recognized by the National Committee for Quality Assurance and *U.S. News and World Report*. That achievement is unparalleled nationally.

Under the Global Waiver, two general goals are proposed for Rite Care:

- RC 4.2 A- To increase access to and improve the quality of care for Medicaid families eligible for the Demonstration
- RC 4.2 B- To expand access to health coverage to all eligible pregnant women and all eligible uninsured children

A series of objectives support the goals of Rite Care. These objectives are:

- RC 4.2.1 To reduce uninsurance in the expansion population groups eligible for the demonstration
- RC 4.2.2 To provide all enrollees in the demonstration with a *medical home*
- RC 4.2.3 To improve access to health care for populations eligible for the demonstration
- RC 4.2.4 To increase the appropriate use of inpatient hospitals and hospital emergency departments
- RC 4.2.5 To reduce infant mortality
- RC 4.2.6 To improve maternal and child health outcomes
- RC 4.2.7 To have a high satisfaction level with the demonstration project among enrolled populations

Under the Global Waiver, the following evaluation questions are proposed for RItE Care. They are based upon the initial series of hypotheses which were articulated by Rhode Island prior to the implementation of RItE Care.

Evaluation Question RC 4.2.1.1: Will the rate of uninsurance in the expansion population groups eligible for RItE Care be reduced as a result of this Demonstration?

Evaluation Question RC 4.2.2.2: Will all RItE Care enrollees have a *medical home*?

Evaluation Question RC 4.2.2.3: Will access to health care for populations eligible for RItE Care enrollment be improved?

Evaluation Question RC 4.2.2.4: Will the appropriate use of inpatient hospitals and hospital emergency departments increase?

Evaluation Question RC 4.2.2.5: Will the rate of infant mortality in the State be reduced during the course of this Demonstration?

Evaluation Question RC 4.2.2.6: Will maternal and child health outcomes for populations enrolled in the Demonstration improve?

Evaluation Question RC 4.2.2.7: Will populations enrolled in RItE Care have a high level of satisfaction with the Demonstration project?

The following proposed evaluation design format is based upon that which had been approved by CMS for RItE Care under Rhode Island's previous Section 1115 waiver authority.

**TABLE 4**

**OVERVIEW OF RITE CARE EVALUATION DESIGN**

Hypothesis	Key Intervention	Data Source(s)	Illustrative Measure(s)
The rate of uninsurance in the expansion population groups eligible for the demonstration will be reduced as a result of this demonstration	Managed Care	<ul style="list-style-type: none"> <li>Current Population Survey (CPS)</li> <li>Behavioral Risk Factor Surveillance Survey (BRFSS)</li> </ul>	<ul style="list-style-type: none"> <li>Percent of Rhode Island population that is uninsured</li> </ul>
All enrollees in the demonstration will have a <i>medical home</i>	Managed Care	<ul style="list-style-type: none"> <li>Encounter Data System</li> <li>HEDIS®</li> </ul>	<ul style="list-style-type: none"> <li>Primary care practitioner (PCP) assignment</li> <li>Child and Adolescent to PCPs</li> <li>Adult Access to Prev./Ambulatory Health Services</li> </ul>
Access to health care for populations eligible for the	Managed Care	<ul style="list-style-type: none"> <li>HEDIS®</li> </ul>	<ul style="list-style-type: none"> <li>Child and Adolescent Access to PCPs</li> <li>Adult Access to Prev./Ambulatory Health</li> </ul>

Hypothesis	Key Intervention	Data Source(s)	Illustrative Measure(s)
demonstration will be improved.			Services <ul style="list-style-type: none"> <li>Well-Child Visits</li> <li>Adolescent Well-Care Visits</li> <li>Prenatal and Postpartum Care</li> <li>Frequency of Ongoing Prenatal Care</li> </ul>
The appropriate use of inpatient hospitals and hospital emergency departments will increase.	Managed Care	<ul style="list-style-type: none"> <li>Encounter Data System</li> <li>Clinical Focused Study</li> </ul>	<ul style="list-style-type: none"> <li>Use of hospital EDs for ambulatory-sensitive conditions</li> <li>Presence of a medical emergency</li> </ul>
The rate of infant mortality in the State will be reduced during the course of this demonstration.	Managed Care	<ul style="list-style-type: none"> <li>Vital Statistics</li> </ul>	<ul style="list-style-type: none"> <li>Infant mortality rate per 1,000 births</li> <li>Postneonatal mortality rate per 1,000 births</li> </ul>
Maternal and child health outcomes for populations enrolled in the demonstration will improve.	Managed Care	<ul style="list-style-type: none"> <li>Vital Statistics</li> </ul>	<ul style="list-style-type: none"> <li>Month of entry into prenatal care</li> <li>Adequacy of prenatal care</li> <li>Maternal smoking</li> <li>Interbirth interval</li> <li>Percent low birthweight births</li> </ul>
Populations enrolled in the demonstration will have a high level of satisfaction with the demonstration project.	Managed Care	<ul style="list-style-type: none"> <li>CAHPS<sup>®</sup></li> <li>Member Satisfaction Survey</li> <li>Complaints, Grievances and Appeals</li> </ul>	<ul style="list-style-type: none"> <li>Rating of All Health Care</li> <li>Rating of Health Plan</li> <li>Getting Care Quickly</li> <li>Getting Needed Care</li> <li>Overall Satisfaction with RItE Care</li> <li>Satisfaction with Health Plan</li> <li>Ability to Receive Timely Care</li> <li>Number of complaints, grievances and appeals by type</li> </ul>

### 4.3 EVALUATION PLAN - RITE SHARE

The purpose of the RItE Share premium assistance program is to support families in their efforts to obtain or maintain private, employer-sponsored health insurance (ESI). Enrollment in RItE Share is now mandatory for Medicaid-eligible individuals whose employers offer a DHS-approved health plan that meet cost-effectiveness requirements under Section 1906 of the Social Security Act as defined in the Rhode Island Medicaid State Plan.

The RItE Share premium assistance program was implemented in February 2001 by signing up “participating employers” on a voluntary basis. Even though active marketing occurred, participation of employers was limited. In January 2002, the State began paying participating employees’ premium share amounts directly to the employees without employers having to sign up and participate in RItE Share. At the same time, enrollment in RItE Share became mandatory for Medicaid-eligible individuals whose employers offered an approvable health plan.

It should be noted that to discourage *crowd-out* (i.e., substituting public coverage for ESI), the State is using a combination of the mandatory enrollment in RItE Share and cost-sharing. It should also be noted that RItE Share provides wraparound coverage where the State also pays for any deductibles, co-payments, coinsurance, and wrap-around benefits for services covered under the Medicaid State Plan but not covered under ESI. These costs are referred to as *Supplementary Benefits*<sup>7</sup>.

When RItE Share started, the State began transitioning RItE Care members into RItE Share. At the time RItE Share became mandatory, it was estimated that there were 7,000 workers, employed by 4,500 companies, who were eligible to be transitioned to RItE Share. However, not all workers are eligible for commercial health insurance through their employers because of, for example, part-time employment or probationary periods.

**Under the Global Waiver, the goal of RItE Share is:** To expand access to health coverage to all eligible pregnant women and all eligible uninsured children and adults

**Under the Global Waiver, the objective is:** To provide a cost-effective alternative to Medicaid eligibility through mandatory participation in employer-sponsored insurance.

The following evaluation questions are posed for RItE Share:

**RS 4.3.1-** Will Medicaid-eligible individuals avail themselves of ESI?

**RS 4.3.2-** Will a premium subsidy program be cost-effective?

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<sup>7</sup> It should be noted that under both RItE Care and RItE Share there are out-of-plan benefits that are paid for apart from any other payments. For RItE Share, these are called “wraparound” services that represent benefits that the Rhode Island Medicaid program covers, but that ESI coverage does not. The costs of these “wraparound” services under RItE Share are assumed to be equivalent to what the costs would have been under RItE Care and are, therefore, not included in the present analysis.

Table 5 below shows the measures and data sources for evaluating RItE Share.

**Table 5**  
**OVERVIEW OF RITE SHARE EVALUATION DESIGN**

Evaluation Question	Key Intervention	Illustrative Measure(s)	Data Source(s)
Will Medicaid-eligible individuals avail themselves of ESI?	RItE Share	Enrollment as of End of Reporting Period	MMIS
Will a premium subsidy program be cost-effective?	RItE Share	Gross and Net Savings	MMIS

It should be noted that the State has been reporting RItE Share enrollment to CMS for the past eight years on monthly, quarterly, and annual bases and has been reporting savings data to CMS for the past five years on an annual basis.

#### **4.4 EVALUATION PLAN – EXTENDED FAMILY PLANNING (EFP)**

Paragraph 57(b) of the June 18, 2008 STCs for Rhode Island’s Section 1115 Demonstration Waiver (CMS Waiver No. 11-W-00004/1) requires:

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:

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

##### **4.4.1 THE FAMILY PLANNING COMPONENT OF RHODE ISLAND’S DEMONSTRATION**

The State believes it important that what constitutes the family planning component of the Demonstration provide an important context for the approach contained herein.

Rhode Island has never had a defined age group for the extended family planning (EFP) program component of the Demonstration. From August 1, 1994 to September 30, 2008, eligibility for EFP is 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 post-partum. These women can be enrolled in EFP, where they receive only family planning benefits, for up to two years as a means to avert a future Medicaid-funded birth.

The 250 percent of the FPL eligibility level for EFP was designed to coordinate precisely with the State’s eligibility level for pregnant women in the Demonstration. However, the extension of the Demonstration lowers the EFP eligibility level to 200 percent of the FPL effective October 1, 2008.

Since the year before the Demonstration began, 1993, there has been an average of 4,477 Medicaid-funded births annually – not all of which have been paid for under the Demonstration, as not all of the Medicaid-eligible persons in the State are enrolled in the Demonstration. Over the past four fiscal years, the average number of EFP enrollees has been 608. Consequently, those women enrolling in EFP after their loss of comprehensive Medicaid benefits under the Demonstration have represented at most 14 percent of all Medicaid-funded births in a year.

The foregoing means that the EFP program component of the Demonstration is constituted of small numbers. Beginning October 1, 2008, corresponding to the Demonstration extension period, these already small numbers are further affected by two very important factors incorporated into the STCs for the Demonstration as a consequence of a change in CMS policy. First, the eligibility level will be lowered from 250 to 200 percent of the FPL. Second, the period for which EFP enrollees will be eligible for Demonstration benefits is modified. Going forward, EFP enrollees will be required to recertify for benefits after one year of participation. Contingent upon the approval of the recertification request, the EFP enrollee may be approved for a second and final year of coverage. In addition, because of legislation enacted by the Rhode Island General Assembly, the eligibility level of parents has reduced from 185 to 175 percent of the FPL effective October 1, 2008. Thus, the State expects the average number of EFP enrollees to be reduced by as much as fifty percent.

#### **4.4.2 EFP EVALUATION DESIGN OVERVIEW**

The goal of the EFP component of the Demonstration is an integral component of one of Rhode Island's three over-arching goals for its Demonstration: to control the rate of growth in the Medicaid budget for the eligible population. With respect to EFP, the objectives are:

- 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

Under the 1115 Waiver, the State has put forward a set of organizing hypotheses (instead of evaluation questions, *per se*) for the evaluation of its Demonstration Waiver. In keeping with that principle, the hypotheses for the EFP component of the Demonstration are as follows:

- The rate of Medicaid-funded births for women eligible for the Demonstration will decrease
- The percentage of Medicaid-funded births with short inter-birth intervals will decrease

Table 6 shows the evaluation design for the EFP component of the Demonstration. For each of the above hypotheses that were shown, the table shows:

- Data Source(s)
- Measure
- Periodicity
- Whether there will be a sample or not

**Table 6**

**OVERVIEW OF EFP EVALUATION DESIGN**

<b>Hypothesis</b>	<b>Data Source</b>	<b>Measure</b>	<b>Periodicity</b>	<b>Sample?</b>
The rate of Medicaid-funded births for women eligible for the Demonstration will decrease	Encounter Data System	Births per 1,000 women aged 15-44 enrolled in the Demonstration	Annually	No
The percentage of Medicaid-funded births with short inter-birth intervals will decrease	Vital Statistics Birth File	Percent of women on Medicaid waiting at least 18 months between births	Annually	No

The proposed design reflects the methodology agreed to by CMS following a series of discussions during the Summer of 2008 about Rhode Island's EFP evaluation design.

The details of the EFP evaluation design are included in this document as Appendix B, which was submitted to CMS on August 26, 2008.

#### 4.5 EVALUATION PLAN – FOCUSED EVALUATIONS FOR EXPANSION GROUPS

Section 4.1 of the proposed Evaluation Design for the Section 1115 (a) Global Consumer Choice Compact outlined the objectives which support the Global Waiver’s principal goal: to rebalance the State’s Medicaid-funded long-term care (LTC) system.

Anticipated outcome indicators for the rebalancing initiative are a controlled rate of growth of the State’s Medicaid budget and budget neutrality calculated over the life of the life of the Demonstration, rather than on an annual basis.

The State’s proposed evaluation of its aged and disabled target population (applicants and beneficiaries of Medicaid-funded LTC) was described previously in Section 4.1.

Likewise, the State’s proposed evaluation plans for RItE Care and RItE Care for Children with Special Health Care Needs were delineated in Section 4.2 and for RItE Share in Section 4.3. As required in Section XVI of the Special Terms and Conditions for the Section 1115 (a) Global Consumer Choice Compact<sup>8</sup>, the following expansion groups will be addressed in focused evaluations:

- Continued Medicaid eligibility for parents of children in temporary State custody
- Coverage of detection and intervention services for at risk young children
- Elders 65 and over
- Extended Family Planning<sup>9</sup>
- HCBS for adults with disabilities
- HCBS for at risk/Medicaid eligible youths
- HCBS for children and youths in residential diversion
- HCBS for frail elders<sup>10</sup>
- HIV Services
- Uninsured adults with mental illness/substance abuse problems (MI/SA)

Medicaid claiming processes for costs not otherwise matchable (CNOM) have been established in conjunction with the Global Waiver. The acronym “CNOM” refers to these processes. The following matrix provides an overview of the relevant benefit package available to each of the CNOM Eligibility Groups.

#### CNOM ELIGIBILITY AND SERVICE GROUPS: BENEFIT PACKAGE MATRIX

CNOM Eligibility Group	Demonstration Budget Population Group	Benefit
Children and families in managed care enrolled in RItE Care (children under 19 & parents). Parents with behavioral health conditions (substance abuse/mental illness) that result in their children being placed in	Budget Population 8 Substitute Care	<ul style="list-style-type: none"> <li>• Under development as 07/01/2009</li> </ul>

<sup>8</sup> *Rhode Island Global Consumer Choice Compact – 1115 Waiver Demonstration, January 2009 – December 2013* (CMS), Special Terms and Conditions, Number 95, p. 45.

<sup>9</sup> The proposed evaluation design for Budget Population 5 (Extended Family Planning) was presented previously in Chapter IV, Section 4.4.

<sup>10</sup> It is implicit in Rhode Island’s proposed evaluation design that the utilization of all home- and community-based services will be analyzed over the course of the Demonstration Waiver.

CNOM Eligibility Group	Demonstration Budget Population Group	Benefit
temporary State custody. Income up to 200% FPL.		
Medicaid eligible 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. Income up to 300% of SSI.	Budget Population 9 & Budget Services Group 4 CSHCN not voluntarily placed in State custody	<u>Limited Benefit Program:</u> <ul style="list-style-type: none"> <li>• Home- and community-based services for Budget Population 9</li> </ul> <p>Expanded Medicaid Benefit for Budget Services Group 4:</p> <ul style="list-style-type: none"> <li>• <u>Home- and community-based services</u></li> </ul>
Individuals 65 and over at risk for long-term care (LTC) who are in need of home- and community-based services (State only group). Income at or below 200% FPL.	Budget Population 10 Elders at risk for long-term care (LTC)	<u>Limited Benefit Program:</u> <ul style="list-style-type: none"> <li>• Home- and community-based services</li> </ul>
Adults with disabilities served by the Office of Rehabilitative Services (ORS) who are not eligible for Medicaid, but who 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	<u>Limited Benefit Program:</u> <ul style="list-style-type: none"> <li>• Home- and community-based services</li> </ul>
Services for uninsured adults with mental illness and/or substance abuse problems who are at risk for a hospital level of care. Income up to 200% FPL.	Budget Population 16 Uninsured adults with mental illness	<u>Limited Benefit Program:</u> <ul style="list-style-type: none"> <li>• Home- and community-based services</li> </ul>
Children under age 18 who are at risk for Medicaid or institutional care not eligible for Medicaid. Income up to 300% SSI.	Budget Population 17 Youth at risk for Medicaid	<u>Limited Benefit Program:</u> <ul style="list-style-type: none"> <li>• Home- and community-based services</li> </ul>
HIV positive individuals who are otherwise not eligible for Medicaid. Income at or below 200% FPL.	Budget Population 18 HIV	<u>Limited Benefit Program:</u> <ul style="list-style-type: none"> <li>• Under development as of 07/01/2009</li> </ul>

CNOM initiatives have been launched for the following Budget Populations and Budget Services Group:

- Budget Population 9 & Budget Services Group 4
- Budget Population 10
- Budget Population 15
- Budget Population 16
- Budget Population 17

As of July 1, 2009, two CNOM initiatives are still under development. By design, the State's Global Consumer Choice Compact is an innovative and dynamic work in progress. Thus, the focused evaluation plans for Budget Population 8 and Budget Population 18<sup>11</sup> will be addressed as inter-departmental planning for these CNOM initiatives become finalized.

The primary goal for this component of the Evaluation Design, which includes each of the Global Waiver's expansion groups, is to provide cost-effective services that will ensure that individuals receive the most appropriate services in the least restrictive and most appropriate setting. For each of the expansion groups listed above, Rhode Island has set forth a series of objectives to support the primary goal of "most appropriate care, least restrictive setting". Flowing from these objectives are a series of evaluation questions and related measures which pertain to the number of individuals served, the utilization of CNOM benefit services, and associated costs. Over the course of the Global Waiver, Rhode Island will analyze whether the provision of limited benefits to the CNOM Budget Population Groups has helped to control Medicaid expenditures.

**Focused Evaluation: Continued Medicaid eligibility for parents of children in temporary State custody (Budget Population 8)**

All of the objectives, evaluation questions and measures outlined in Section 4.2 for RItE Care will be used to evaluate the enrollment and service utilization trends for this expansion population. This expansion group will be enrolled on a mandatory basis in RItE Care; the State's Medicaid managed care delivery system.

**Focused Evaluation: 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 (Budget Population 9 & Budget Services Group 4).**

**CNOM Goal:** To provide a limited benefit package for children with special health care needs (CHSCN) who have not been voluntarily placed in State custody, thereby allowing these children and youths to function in the least restrictive environment. **CNOM Objective 4.5.1:** To increase access for CSHCN to a designated set of home- and community-based services.

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<sup>11</sup> Ibid, p. 21.

Evaluation Question CNOM 4.5.1.1: Over the course of the Global Waiver, how many applicants were approved to receive the designated home- and community-based services available to CSHCN in Budget Population 9 and Budget Services Group 4?

Measure: The State will quantify how many applicants for the designated home- and community-based services available to Budget Population 9 and Budget Services Group 4 were approved to receive the limited benefits program.

Evaluation Question CNOM 4.5.1.2: Over the course of the Global Waiver, has there been a change in the utilization of home- and community-based services by CSHCN approved to receive a limited set of benefits which are available to Budget Population 9 and Budget Services Group 4?

Measure: Over the course of the Global Waiver, the State will quantify the utilization of home- and community-based services by CSHCN approved to receive a limited set of benefits which are available to Budget Population 9 and Budget Services Group 4.

**Focused Evaluation: 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 (Budget Population 9 & Budget Services Group 4)**

**CNOM Goal:** To provide a limited benefit package for children with special health care needs (CHSCN) to who have not been voluntarily placed in State custody, thereby allowing them to function in the least restrictive environment. **CNOM Objective 4.5.2:** To provide a cost-effective, home- and community-based alternative to institutional care for CSHCN.

Evaluation Question CNOM 4.5.2.1: Over the course of the Global Waiver, has the utilization of home- and community-based services prevented or delayed the placement of CSHCN in a LTC facility?

Measure: Over the course of the Global Waiver, the State will analyze admissions to LTC facilities for CSHCN who are approved for participation in Budget Population 9 and Budget Services Group 4.

Evaluation Question CNOM 4.5.2.2: Will a month of home- and community-based services cost less than the projected monthly cost of a stay in a LTC facility for Budget Population 9 and Budget Services Group 4?

Measure: The State will compare the cost of a care plan for home- and community-based care services for children and youth approved to participate in Budget Population 9 and Budget Services Group 4 to the projected cost of a one-month stay in a LTC facility.

**Focused Evaluation: Elders 65 and over at risk for LTC who are in need of home- and community-based services (Budget Population 10)**

**CNOM Goal:** To assist low-income elders over the age of 65 who are not eligible for Medicaid to maintain optimum health and functioning in the least restrictive environment by providing home- and community based services to qualified beneficiaries. **CNOM Objective 4.5.3:** To improve clients' stability and functioning in home- and community-based settings.

Evaluation Question CNOM 4.5.3.1: Over the course of the Global Waiver, how many applicants were approved to receive the designated home- and community-based services available to Budget Population 10?

Measure: The State will quantify how many applicants for the designated home- and community-based services available to Budget Population 10 were approved for these limited benefits.

Evaluation Question CNOM 4.5.3.2: Over the course of the Global Waiver, has there been a change in the utilization of home- and community-based services by individuals approved for Budget Population 10's limited benefit program?

Measure: The State will quantify the utilization of the home- and community-based services available to Budget Population 10 over the course of the Global Waiver.

Evaluation Question CNOM 4.5.3.3: Over the course of the Global Waiver, will the utilization of services prevent or delay placement in a LTC facility for at least six (6) months?

Measure: Over the course of the Global Waiver, the State will analyze admissions to LTC facilities for individuals approved for Budget Population 10.

**CNOM Goal:** 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. **CNOM Objective 4.5.4:** To provide a cost-effective alternative to facility-based LTC.

Evaluation Question CNOM 4.5.4.1: Will a month of home- and community-based services cost less than the projected monthly cost of a stay in a LTC facility?

Measure: The State will compare the cost of a care plan for home- and community-based care services to the projected cost of a one-month stay in a LTC facility.

**Focused Evaluation: Adults with disabilities served by the Office of Rehabilitative Services (ORS) who are not eligible for Medicaid, but who may become so if these services are not provided (Budget Population 15)**

**CNOM Goal:** To provide a limited benefit program for adults with disabilities who are at risk for long-term care, thereby promoting their ability to function in the least restrictive environment. **CNOM Objective 4.5.5:** To increase adults with disabilities' access to a designated set of home- and community-based services.

Evaluation Question CNOM 4.5.5.1: Over the course of the Global Waiver, how many applicants were approved to receive the designated home- and community-based services available to Budget Population 15?

Measure: The State will quantify how many adults with disabilities who applied for the designated home- and community-based services available to Budget Population 15 were approved to receive the limited benefits program.

Evaluation Question CNOM 4.5.5.2: Over the course of the Global Waiver, has there been a change in the utilization of home- and community-based services by adults with disabilities who have been approved to receive Budget Population 15's benefit package?

Measure: The State will quantify the utilization of the home- and community-based services available to adults with disabilities who have been approved to participate in Budget Population 15 over the course of the Global Waiver.

**Focused Evaluation: Adults with disabilities served by the Office of Rehabilitative Services (ORS) who are not eligible for Medicaid, but who may become so if these services are not provided (Budget Population 15)**

**CNOM Goal:** To provide a limited benefit program for adults with disabilities who are at risk for long-term care, thereby promoting their ability to function in the least restrictive environment. **CNOM Objective 4.5.6:** To provide a cost-effective, home- and community-based alternative to institutional care for adults with disabilities.

Evaluation Question CNOM 4.5.6.1: Over the course of the Global Waiver, has the utilization of home- and community-based services prevented or delayed the placement of adults with disabilities in a LTC facility?

Measure: Over the course of the Global Waiver, the State will analyze admissions to LTC facilities for adults with disabilities who were approved for participation in Budget Population 15.

Evaluation Question CNOM 4.5.6.2: Will a month of home- and community-based services cost less than the projected monthly cost of a stay in a LTC facility for Budget Population 15?

Measure: The State will compare the cost of a care plan for home- and community-based care services for adults with disabilities approved to participate in Budget Population 15 to the projected cost of a one-month stay in a LTC facility.

**Focused Evaluation: Services for low income uninsured adults with mental illness and/or substance abuse (MI/SA) problems who are at risk for a hospital level of care (Budget Population 16)**

**CNOM Goal:** To provide cost-effective services that will ensure that recipients receive the most appropriate services in the least restrictive and most appropriate setting.

**CNOM Objective 4.5.7:** To increase access for uninsured adults with mental illness and/or substance abuse problems to a designated set of community-based services.

Evaluation Question CNOM 4.5.7.1: Over the course of the Global Waiver, how many uninsured adults with MI/SA problems who applied were approved to receive the designated community-based services available to Budget Population 16?

Measure: The State will quantify how many uninsured adults with MI/SA problems who applied for the designated home- and community-based services available to Budget Population 16 were approved to receive the limited benefits program.

Evaluation Question CNOM 4.5.7.2: Over the course of the Global Waiver, has there been a change in the utilization of community-based MI/SA treatment services by uninsured adults who were approved to participate in Budget Population 16?

Measure: The State will quantify the utilization of the community-based MI/SA treatment services by adults who were approved to participate in Budget Population 16 over the course of the Global Waiver.

**Focused Evaluation: Services for uninsured adults with mental illness and/or substance abuse (MI/SA) problems who are at risk for a hospital level of care (Budget Population 16)**

**CNOM Goal:** To provide cost-effective services that will ensure that recipients receive the most appropriate services in the least restrictive and most appropriate setting.

**CNOM Objective 4.5.8:** To reduce the number of Medicaid-paid psychiatric inpatient admissions and inpatient admissions for drug/alcohol detoxification.

Evaluation Question CNOM 4.5.8.1: Over the course of the Global Waiver, will there be a decrease in the number of Medicaid-paid psychiatric admissions and inpatient admissions for drug/alcohol detoxification?

Measure: The State will analyze the rate of psychiatric admissions and detoxification admissions per 1,000 member months. Rhode Island will determine whether over the course of the Global Waiver there has been a decrease in the number and percentage of Medicaid-paid psychiatric admissions and detoxification admissions.

**Focused Evaluation: Services for uninsured adults with mental illness and/or substance abuse (MI/SA) problems who are at risk for a hospital level of care (Budget Population 16)**

**CNOM Goal:** To provide cost-effective services that will ensure that recipients receive the most appropriate services in the least restrictive and most appropriate setting.

**CNOM Objective 4.5.9:** To reduce the average inpatient MI/SA length of stay (ALOS).

Evaluation Question CNOM 4.5.9.1: Will there be a reduction in inpatient MI/SA ALOS over the course of the Global Waiver?

Measure: The State will calculate its inpatient psychiatric and inpatient detoxification days per thousand member months over the course of the Global Waiver.

**Focused Evaluation: Services for uninsured adults with mental illness and/or substance abuse (MI/SA) problems who are at risk for a hospital level of care (Budget Population 16)**

**CNOM Goal:** To provide cost-effective services that will ensure that recipients receive the most appropriate services in the least restrictive and most appropriate setting.

**CNOM Objective 4.5.10:** To reduce inpatient readmissions within 30 days of MI/SA hospital discharges.

Evaluation Question CNOM 4.5.10.1: Will there be a reduction in inpatient readmissions within 30 days of MI/SA hospital discharges?

Measure: The State will calculate the 30-day readmission rate for MI/SA inpatient stays.

**Focused Evaluation: Children under age 18 who are at risk for Medicaid or institutional care who are not eligible for Medicaid. (Budget Population 17)**

**CNOM Goal:** To provide a limited benefit package for children less than 18 years of age who are at risk for institutional care, thereby allowing these children to function in the least restrictive environment. **CNOM Objective 4.5.11:** 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.

Evaluation Question CNOM 4.5.11.1: Over the course of the Global Waiver, how many applicants (children less than 18 years of age who were at risk for institutional care) were approved to receive the designated home- and community-based services available to Budget Population 17?

Measure: The State will quantify how many children less than 18 years of age who were at risk for institutional care were approved to receive the designated home- and community-based services available to Budget Population 17.

Evaluation Question CNOM 4.5.11.2: Over the course of the Global Waiver, has there been a change in the utilization of home- and community-based services by children under 18 years of age who were approved to participate in Budget Population 17's limited benefit package?

Measure: Over the course of the Global Waiver, the State will quantify the utilization of home- and community-based by children less than 18 years of age who were approved to participate in Budget Population 17's limited benefit program.

**Focused Evaluation: Children under age 18 who are at risk for Medicaid or institutional care who are not eligible for Medicaid. (Budget Population 17)**

**CNOM Goal:** To provide a limited benefit package for children less than 18 years of age who are at risk for institutional care, thereby allowing these children to function in the least restrictive environment. **CNOM Objective 4.5.12:** 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 for institutional care.

Evaluation Question CNOM 4.5.12.1: Over the course of the Global Waiver, has the utilization of home- and community-based services prevented or delayed the placement of children who are Budget Population 17 approved in a LTC facility?

Measure: Over the course of the Global Waiver, the State will analyze Medicaid-paid admissions to LTC facilities for children who were approved for participation in Budget Population 17.

**Focused Evaluation: HIV+ individuals who are otherwise not eligible for Medicaid (Budget Population 18)**

The focused evaluation plan for Budget Population 18 will be developed as inter-departmental planning for this CNOM initiative becomes finalized.

#### 4.6 Use of Contractors

Multiple contractors may be used to perform the various evaluation activities identified in the Global Waiver's evaluation plan.

#### 4.7 How the effects of the Demonstration shall be isolated from other initiatives occurring in the State

There are two initiatives underway in the State that may have some impact on certain areas of the Global Consumer Choice demonstration:

- **Real Choices Grant** – The State was awarded a Real Choices Systems Change Grant by CMS on September 30, 2006. There are three goals for the grant for Rhode Island:
  - Improve access to LTC support services by increasing awareness of client knowledge of HCBS
  - Develop a quality management strategy using existing data sets (i.e., RI Hospital Discharge, BRFSS, and MDS)
  - Develop effective payment methodologies by reviewing existing methodologies to assess effectiveness of incentives to rebalance.
  
- **Emergency Room Diversion Grant** – The State was awarded a Medicaid Emergency Room Diversion grant from the CMS on April 14, 2008. The grant period runs for two years. To carry out this grant initiative, the Department of Human Services has engaged a contractor to increase capacity in the alternative non-emergency provider network to further its commitment to the “right services, at the right time, and in the right setting” and to decrease non-emergency utilization of emergency departments within the Medicaid population for beneficiaries with ambulatory-sensitive conditions, complex acute medical and behavioral health conditions, and long-term care needs. The goals of the grant include:
  - Promoting primary care
  - Identifying and improving access to non-emergency care in alternate settings
  - Reducing the rate of non-emergency use of the emergency department
  - Expanding opportunities for beneficiaries to participate in and direct their own care.

Because these initiatives address some of the goals and objectives of the Global Waiver Demonstration, the work under these grants is actually being coordinated with the Demonstration's implementation effort. Therefore, the State will not isolate the effects of these grants as part of the Global Consumer Choice Compact 1115 Waiver Demonstration's evaluation design.

# Appendix A

## APPENDIX A

### EVALUATION DESIGN FRAMEWORK FOR THE GLOBAL CHOICE WAIVER

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
<b>Total Demonstration</b>	To control the rate of growth of the State's Medicaid expenditures		Have the overall costs of providing Medicaid-covered services to population groups eligible prior to the Demonstration been controlled?	Total Medicaid Expenditures Subject to the Global Aggregate Cap	MMIS
<b>Long-Term Care (LTC) Reform (SECTION 4.1)</b>	LTC 4.1- To undertake measurable reform of Rhode Island Medicaid's long-term care program	LTC 4.1.1- To rebalance the State's existing long-term care system with home- and community-based services	LTC 4.1.1.1- Over the course of the Global Waiver, has there been a change in the number of admissions to LTC facilities (nursing facilities and ICF/MRs) paid by Medicaid?	Average Daily Census of Medicaid-paid Residents Who Are Aged or Disabled in Institutional Care	MMIS
		LTC 4.1.2- To increase the utilization of home- and community-based services in Rhode Island	LTC 4.1.1.2- Over the course of the Global Waiver, has there been a change in the number and percentage of discharges from LTC facilities to home and community-based settings?	Medicaid-Paid Home and Community Based Care Utilization	MMIS
		LTC 4.1.3- To modify the State's income and resource eligibility requirements for Medicaid-funded long-term care services	LTC 4.1.1.3- Over the course of the Global Waiver, has there been a change in the average length of stay (ALOS) / in LTC facilities by Medicaid aged and disabled beneficiaries?	Medicaid-Paid Institutional Care Days	MMIS

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
			<p><b>LTC 4.1.1.4-</b> Over the course of the Global Waiver, has the average daily census in LTC facilities (nursing facilities and ICF/MRs) changed for Medicaid aged and disabled beneficiaries?</p>	<p>Average Daily Census of Medicaid-paid Residents Who Are Aged or Disabled in Institutional Care</p>	MMIS
			<p><b>LTC 4.1.1.5-</b> Has the cost of care provided to Medicaid aged and disabled beneficiaries in LTC facilities been controlled over time?</p>	<p>Medicaid Expenditures for Aged and Disabled Beneficiaries in Institutional Care</p>	MMIS
			<p><b>LTC 4.1.2.1-</b> Over the course of the Global Waiver, has there been a change in the volume of beneficiaries receiving one or more core home- and community-based services, such as assisted living, private duty nursing, or shared living?</p>	<p>Medicaid-Paid Institutional Care Days</p>	MMIS
			<p><b>LTC 4.1.2.2-</b> Over the course of the Global Waiver, has there been a change in the utilization of core home- and community-based services?</p>	<p>Medicaid Expenditures for Aged and Disabled Beneficiaries in Home and Community-Based Care</p>	MMIS
			<p><b>LTC 4.1.2.3-</b> Has the utilization distribution of Medicaid aged and disabled beneficiaries shifted between LTC facilities and home- and community-based care services?</p>	<p>Aged and Beneficiary Enrollment in Systems of Care</p>	MMIS
				<p>Medicaid-Paid Home and Community Based Care Utilization</p>	MMIS
				<p>Number of clients who were approved to receive LTC facility-based services</p>	MMIS

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
	<p><b>LTC 4.2-</b> To establish objective, needs-based level of care determinations for Medicaid long-term care applicants and beneficiaries</p>	<p><b>LTC 4.2.1-</b> 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</p>	<p><b>LTC 4.1.2.4-</b> Has the cost distribution for Medicaid aged and disabled beneficiaries shifted between LTC facilities and home- and community-based services?</p> <p><b>LTC 4.1.3.1-</b> How many Medicaid LTC applicants meet the revised financial eligibility thresholds based upon the State's new spousal impoverishment rules for individuals who are medically needy in special income-level group (i.e., Budget Populations 11, 12, and 13)?</p> <p><b>LTC 4.1.3.2-</b> How many LTC applicants who meet the new financial eligibility thresholds remain in home- or community-based settings rather than enter an LTC facility?</p> <p><b>LTC 4.2.1.1-</b> How many new LTC applicants meet the State's level of care categories: highest, high, and preventive? How many new Medicaid LTC applicants do not meet any of these three levels of care?</p>	<p>Medicaid Expenditures for Aged and Disabled Beneficiaries in Home and Community-Based Care</p> <p>Medicaid Expenditures for Aged and Disabled Beneficiaries in Institutional Care</p> <p>Enrollment as of the End of the Reporting Period</p> <p>Number of clients who were approved to receive home- and community-based services</p>	<p>MMIS</p> <p>MMIS</p> <p>MMIS</p> <p>MMIS</p>

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
	<p><b>LTC 4.3-</b> To limit the rate of growth of the State's Medicaid expenditures</p>	<p><b>LTC 4.3.1-</b> To control expenditure growth by implementing the above objectives</p>	<p><b>LTC 4.2.1.2-</b> How many new Medicaid LTC applicants whose level of care needs were classified in the highest category received home- and community based services?</p> <p><b>LTC 4.2.1.3-</b> How many of the State's current (enrolled prior to 7/1/09) LTC beneficiaries whose level of care needs were classified in the highest category at the time of eligibility redetermination received home- and community-based services and how many received care in LTC facilities?</p> <p><b>LTC 4.2.1.4-</b>Over the course of the Global Waiver, how many new Medicaid LTC applicants whose level of care needs were classified as meeting the preventive level of care criteria received preventive-level services?</p> <p><b>LTC 4.2.1.5-</b> Over the course of the Global Waiver, has there been a change in utilization of preventive care services?</p> <p><b>LTC 4.3.1.1-</b> Have the overall costs of providing Medicaid-covered services to population groups eligible prior to the implementation of the Global Waiver been controlled?</p>	<p>Number of clients who were approved to receive preventive level services</p> <p>Medicaid-Paid Home and Community Based Preventive Services Utilization</p>	<p>MMIS</p> <p>MMIS</p> <p>MMIS</p>

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
		<p data-bbox="804 544 1151 660"><b>LTC 4.3.2-</b> To implement selective contracting based upon Rhode Island’s purchasing analyses</p> <p data-bbox="804 1114 1151 1321"><b>LTC 4.3.3-</b> 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</p>	<p data-bbox="1189 308 1554 483"><b>LTC 4.3.2.1-</b> Over the course of the Global Waiver, how many selective contracting strategies were initiated by the State? How many contractors were engaged to provide services?</p> <p data-bbox="1189 515 1554 660"><b>LTC 4.3.2.2-</b> Over the course of the Global Waiver, has there been a change in utilization of services covered by selective contracting arrangements?</p> <p data-bbox="1189 724 1554 963"><b>LTC 4.3.2.3-</b> Over the course of the Global Waiver, have the selective contracting strategies resulted in controlled Medicaid expenditures for the related services? Refer to Section 4.5- Focused Evaluations of Expansion Groups</p> <p data-bbox="1189 1118 1554 1171">Regarding <b>4.3.3:</b> Please refer to Section 4.5 for CNOM discussion</p>	<p data-bbox="1576 308 1845 395">Quantify the number and types of selective contracting arrangements</p> <p data-bbox="1576 547 1845 635">Quantify the number and types of selective contracting arrangements</p> <p data-bbox="1576 699 1861 810">Medicaid Expenditures for Aged and Disabled Beneficiaries in Home and Community-Based Care</p> <p data-bbox="1576 842 1861 962">Medicaid Expenditures for Aged and Disabled Beneficiaries in Institutional Care</p> <p data-bbox="1576 994 1845 1114">Medicaid-Paid Home and Community Based Preventive Services Utilization</p>	<p data-bbox="1888 427 2067 480">Communications Files</p> <p data-bbox="1888 635 2067 687">Communications Files</p> <p data-bbox="1944 842 2018 866">MMIS</p> <p data-bbox="1944 994 2018 1018">MMIS</p>



Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
<b>RItE Care<sup>12</sup></b>  <b>(SECTION 4.2)</b>	<b>RC 4.2 A-</b> To increase access to and improve the quality of care for Medicaid families eligible for the demonstration  <b>RC 4.2 B-</b> To expand access to health coverage to all eligible pregnant women and all eligible uninsured children and adults  To control the rate of growth in the Medicaid budget for the eligible population <sup>13</sup>	<b>RC 4.2.1-</b> To reduce uninsurance in the expansion population groups eligible for the Demonstration	<b>RC 4.2.1.1-</b> Will the rate of uninsurance in the expansion population groups eligible for the Demonstration be reduced as a result of this Demonstration?	Rate of uninsurance in the State	Current Population Survey
		<b>RC 4.2.2-</b> To provide all enrollees in the Demonstration with a <i>medical home</i>	<b>RC 4.2.2.2-</b> Will all enrollees in the Demonstration have a <i>medical home</i> ?	Enrollment as of the End of the Reporting Period	MMIS
		<b>RC 4.2.3-</b> To improve access to health care for populations eligible for the Demonstration	<b>RC 4.2.2.3-</b> Will access to health care for populations eligible for the Demonstration be improved?	Utilization	Encounter Data System
		<b>RC 4.2.4-</b> To increase the appropriate use of inpatient hospitals and hospital emergency departments	<b>RC 4.2.2.4-</b> Will the appropriate use of inpatient hospitals and hospital emergency departments increase?	Cost-Sharing	MMIS
		<b>RC 4.2.5-</b> To reduce infant mortality	<b>RC 4.2.2.5-</b> Will the rate of infant mortality in the State be reduced during the course of this Demonstration?	Complaints, Grievances and Appeals	Health Plan-specific reports submitted to DHS
		<b>RC 4.2.6-</b> To improve maternal and child health outcomes	<b>RC 4.2.2.6-</b> Will maternal and child health outcomes for populations enrolled in the Demonstration improve?		
		<b>RC 4.2.7-</b> To have a high satisfaction level with the demonstration project among enrolled populations	<b>RC 4.2.2.7-</b> Will populations enrolled in the Demonstration have a high level of satisfaction with the Demonstration project?	Member Satisfaction	CAPHS®

<sup>12</sup> Separate evaluation design submitted to CMS on August 26, 2008.

<sup>13</sup> This was a separate goal for RItE Care when it was a stand-alone Demonstration. Since there will not be a separate budget neutrality test for RItE Care/RItE Share under the Global Waiver, separate evaluation against this goal will be dropped.

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
<b>RItE Share</b> (SECTION 4.3)	<b>RS 4.3-</b> To expand access to health coverage to all eligible pregnant women and all eligible uninsured children and adults	To provide a cost-effective alternative to Medicaid eligibility through mandatory participation in employer-sponsored insurance (ESI)	<b>RS 4.3.1-</b> Will Medicaid-eligible individuals avail themselves of ESI?	Enrollment as of End of Reporting Period	MMIS
			<b>RS 4.3.2-</b> Will a premium subsidy program be cost-effective?	Gross and Net Savings	MMIS
<b>Extended Family Planning Program</b> <sup>14</sup> (SECTION 4.4)	<b>EFP 4.4.1-</b> To control the rate of growth in the Medicaid budget for the eligible population	<b>EFP 4.4.1-</b> To avert future Medicaid-funded births by providing family planning services to Medicaid-eligible women who lost their Medicaid-eligibility 60 days post-partum  <b>EFP 4.4.2-</b> 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	Will the rate of Medicaid-funded births for women eligible for the Demonstration decrease?	Enrollment as of End of Reporting Period  Births per 1,000 women aged 15-44 enrolled in the Demonstration	MMIS  Encounter Data System
			Will the percentage of Medicaid-funded births with short inter-birth intervals decrease?	Percent of women on Medicaid waiting at least 18 months between births	Vital Statistics Birth File
				Family planning patient receiving a clinical referral for primary care	Survey
<b>FOCUSED EVALUATIONS</b>					
Children and families in managed care and continued eligibility for RItE Care parents when kids are in temporary state custody  (SECTION 4.5-	Same as RItE Care	Same as RItE Care	Same as RItE Care	Same as RItE Care	Same as RItE Care

<sup>14</sup> Separate evaluation design submitted to CMS on August 28, 2008. See Appendix B for more detail.

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
<p><b>Budget Population 8)</b> Children with special health care needs (as an eligibility factor) who are under 21 who would otherwise be placed in voluntary State custody – residential diversion</p> <p><b>(SECTION 4.5 – Budget Population 9 &amp; Budget Services Group 4)</b></p>	<p>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.</p>	<p><b>CNOM 4.5-2:</b> To provide a cost-effective, home- and community-based alternative to institutional care for CSHCN.</p>	<p><b>CNOM 4.5-2-1:</b> Over the course of the Global Waiver, has the utilization of home- and community-based services prevented or delayed the placement of CSHCN in a LTC facility?</p> <p><b>CNOM 4.5-2-2:</b> Will a month of home- and community-based services cost less than the projected monthly cost of a stay in a LTC facility for Budget Population 9 &amp; Budget Services Group 4?</p>	<p>Number of clients who were approved to receive home- and community-based services</p> <p>Number of clients receiving more than one or more home- and community-based services</p> <p>Number of times client receiving services entered LTC Facility</p> <p>Total cost of care plan as compared to monthly cost for LTC facility care</p>	<p>MMIS</p>

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
<p>Elders 65 and over <b>(SECTION 4.5- Budget Population 10)</b></p>	<p>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.</p>	<p>To improve client stability and functioning in the community</p> <p>To provide a cost-effective alternative to institutional care</p>	<p><b>CNOM 4.5.3.1-</b> Over the course of the Global Waiver, how many applicants were approved to receive the designated home- and community-based services available to Budget Population 10?</p> <p><b>CNOM 4.5.3.2-</b> Over the course of the Global Waiver, has there been a change in the utilization of core home- and community-based services by individuals approved for Budget Population 10's benefit package?</p> <p><b>CNOM 4.5.3.3-</b> Over the course of the Global Waiver, will the utilization of services to prevent or delay placement in a LTC facility for at least six (6) months?</p> <p><b>CNOM 4.5.4.1-</b> Will a month of home care services cost less than the monthly cost of a LTC facility?</p>	<p>Number of clients who were approved to receive home- and community-based services</p> <p>Number of clients receiving more than one or more home- and community-based services</p> <p>Number of times client receiving services entered LTC Facility</p> <p>Total cost of care plan as compared to monthly cost for LTC facility care</p>	<p>Claims Data</p> <p>DEA Service Data</p> <p>Case Record Review Claims Data</p> <p>Client Satisfaction Survey</p> <p>Case Record Review</p> <p>Claims Data</p>
<p>Adults with disabilities served by the Office of Rehabilitative Services who are not eligible for Medicaid, but who may become so if these services are not provided</p> <p><b>(Section 4.5 – Budget</b></p>	<p>To provide a limited benefit program for adults with disabilities who are at risk for long-term care (LTC), thereby promoting their ability to function in the least restrictive environment.</p>	<p><b>CNOM 4.5-5:</b> To increase adults with disabilities' access to a designated set of home- and community-based services.</p>	<p><b>CNOM 4.5.5.1:</b> Over the course of the Global Waiver, how many applicants were approved to receive the designated set of home- and community-based services available to Budget Population 15?</p> <p><b>CNOM 4.5.5.2:</b> Over the course of the Global Waiver, has there been a change in the utilization of</p>	<p>Number of clients who were approved to receive home- and community-based services</p> <p>Number of clients receiving more than one or more home- and community-based services</p>	<p>MMIS</p>

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
<b>Population 15)</b>		<b>CNOM 4.5-6:</b> To provide a cost-effective, home- and community-based alternative to institutional care for adults with disabilities.	<p>home- and community-based services by adults with disabilities who have been approved to receive Budget Population 15's limited benefit program?</p> <p><b>CNOM 4.5.6.1:</b> Over the course of the Global Waiver, has the utilization of home- and community-based services prevented or delayed the placement of adults with disabilities in a LTC facility?</p> <p><b>CNOM 4.5.6.2:</b> Will a month of home- and community-based services cost less than the projected monthly cost of a stay in a LTC facility for Budget Population 15?</p>	<p>Number of times client receiving services entered LTC Facility</p> <p>Total cost of care plan as compared to monthly cost for LTC facility care</p>	
<p>Uninsured adults with Mental Illness/Substance Abuse (MI/SA) problems</p> <p><b>(SECTION 4.5- Budget Population 16)</b></p>	To provide cost-effective services that will ensure recipients receive the appropriate services in the least restrictive and most appropriate setting	<b>CNOM 4.5.7-</b> To increase access for uninsured adults with mental illness and/or substance abuse problems to a designated set of community-based services	<p><b>CNOM 4.5.7.1-</b> Over the course of the Global Waiver, how many uninsured adults with MI/SA problems who applied were approved to receive the designated community-based services available to Budget Population 16?</p> <p><b>CNOM 4.5.7.2-</b> Over the course of the Global Waiver, has there been a change in the utilization of community-based MI/SA treatment services by uninsured adults who were approved to participate in Budget Population 16?</p> <p><b>CNOM 4.5.8.1-</b> Over the course</p>	<p>Number of clients who were approved to receive community-based services</p> <p>Number of clients receiving more than one or more and community-based services</p> <p>Medicaid-paid community-based MI/SA utilization</p>	<p>MMIS</p> <p>MMIS</p> <p>MMIS</p>

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
		<p><b>CNOM 4.5.8-</b> To reduce the number of Medicaid-paid psychiatric inpatient admissions and inpatient admissions for drug/alcohol detoxification</p> <p><b>CNOM 4.5.9-</b> To reduce the average inpatient MI/SA length of stay (ALOS)</p> <p><b>CNOM 4.5.10-</b> To reduce inpatient readmissions within 30 days of MI/SA hospital discharges</p>	<p>of the Global Waiver, will there be a reduction in the number of Medicaid-paid psychiatric hospitalizations or inpatient detoxification?</p> <p><b>CNOM 4.5.9.1-</b> Will there be a reduction in inpatient MI/SA ALOS over the course of the Global Waiver?</p> <p><b>CNOM 4.5.10.1-</b> Will there be a reduction in inpatient readmissions within 30 days of MI/SA hospital discharges?</p>	<p>Admissions for Psychiatric Hospitalization or Detoxification/1,000 Member-Months</p> <p>Psychiatric Hospital Days or Detoxification/1,000 Member-Months</p> <p>Admissions for Psychiatric Hospitalization or Detoxification/1,000 Member-Months</p> <p>Medicaid-Paid Institutional Care Days</p> <p>Readmission Rate for Psychiatric Hospitalization within 30 Days of Discharge</p>	<p>MMIS</p> <p>MMIS</p> <p>MMIS</p> <p>MMIS</p>
<p>Coverage of detection and intervention services for at-risk young children</p> <p><b>(SECTION 4.5-Budget Population 17)</b></p>	<p>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</p>	<p><b>CNOM 4.5.11-</b> 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</p> <p>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</p>	<p><b>CNOM 4.5.11.1-</b> Over the course of the Global Waiver, how many applicants (children less than 18 years of age who are at risk of institutional care) were approved to receive the designated home- and community-based services available to Budget Population 17?</p> <p><b>CNOM 4.5.11.2-</b> Over the course of the Global Waiver, has there been a change in the utilization of home- and community-based services by children under 18 years of age who were approved to participate in Budget</p>	<p>Number of clients who were approved to receive home- and community-based</p> <p>Number of clients receiving more than one or more home- and community-based services</p> <p>Utilization of home- and community-based services</p>	<p>MMIS</p> <p>MMIS</p> <p>MMIS</p>

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
			Population 17's limited benefit program?		
HIV services <b>(SECTION 4.5- Budget Population 18)</b>	Under Development	Under Development	Under Development	Under Development	Under Development
Administrative process flexibility	To implement changes to Medicaid program more expeditiously	To implement changes to the Medicaid program within STC-specified timeframes	Are changes approved within the timelines specified in the STCs for each category of change?	Days from the date of submission to CMS approval for Category 2 and Category 3 Changes	Communications Files

# **APPENDIX B**

**EVALUATION DESIGN FOR RHODE ISLAND'S EXTENDED FAMILY  
PLANNING (EFP) PROGRAM**

*Center for Child and Family Health*  
*Department of Human Services*  
**State of Rhode Island and Providence Plantations**  
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**600 New London Avenue**  
**Cranston, Rhode Island 02920**  
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**August 2008**

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*This document was submitted to CMS on August 28, 2008.*

This document provides CMS with the Evaluation Plan for the Extended Family Planning (EFP) component of Rhode Island's Section 1115 Demonstration Waiver (CMS Waiver No. 11-W-00004/1).

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Extended Family Planning Program (EFP) Evaluation Design	3

## EXTENDED FAMILY PLANNING (EFP) EVALUATION DESIGN

Paragraph 57(b) of the June 18, 2008 STCs for Rhode Island's Section 1115 Demonstration Waiver (CMS Waiver No. 11-W-00004/1) requires:

“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		
Intra-birth Spacing		
Family Planning Patients Receiving a Clinical Referral for Primary Care	(Estimate may be based on a sample)	

This document is intended to fulfill these requirements.

### 1.1 The Family Planning Component of Rhode Island's Demonstration

The State believes it important that what constitutes the family planning component of the Demonstration provide an important context for the approach contained herein.

Rhode Island has never had a defined age group for the extended family planning (EFP) program component of the Demonstration. From August 1, 1994 to September 30, 2008, eligibility for EFP is 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 post-partum. These women can be enrolled in EFP, where they receive only family planning benefits, for up to two years as a means to avert a future Medicaid-funded birth.

The 250 percent of the FPL eligibility level for EFP was designed to coordinate precisely with the State's eligibility level for pregnant women in the Demonstration. However, the extension of the Demonstration lowers the EFP eligibility level to 200 percent of the FPL effective October 1, 2008.

Since the year before the Demonstration began, 1993, there has been an average of 4,477 Medicaid-funded births annually – not all of which have been paid for under the Demonstration, as not all of the Medicaid-eligible persons in the State are enrolled in the Demonstration. Over the past four fiscal years, the average number of EFP enrollees has been 608. Consequently, those women enrolling in EFP after their loss of comprehensive Medicaid benefits under the Demonstration have represented at most 14 percent of all Medicaid-funded births in a year.

The foregoing means that the EFP program component of the Demonstration is constituted of small numbers. Beginning October 1, 2008, corresponding to the Demonstration extension period, these already small numbers will shrink due to two very important factors incorporated into the STCs for the Demonstration as a consequence of a change in CMS policy. First, the eligibility level will be lowered from 250 to 200 percent of the FPL. Second, the period for which EFP enrollees will be eligible for Demonstration benefits will be modified. Going forward, EFP enrollees will be required to recertify for benefits after one year of participation. Contingent upon the approval of the recertification request, the EFP enrollee will be approved for a second and final year of coverage. In addition, because of legislation recently enacted by the Rhode Island General Assembly, the eligibility level of parents will be reduced from 185 to 175 percent of the FPL effective October 1, 2008. Thus, the State expects the average number of EFP enrollees to be reduced by as much as fifty percent.

## **1.2 EFP Evaluation Design Overview**

The goal of the EFP component of the Demonstration is an integral component of one of Rhode Island's three over-arching goals for its Demonstration: to control the rate of growth in the Medicaid budget for the eligible population. With respect to EFP, the objectives are:

- 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

Traditionally, the State has put forward a set of organizing hypotheses (instead of evaluation questions, per se) for the evaluation of its Demonstration Waiver. In keeping with that principle, the hypotheses for the EFP component of the Demonstration are as follows:

- The rate of Medicaid-funded births for women eligible for the Demonstration will decrease
- The percentage of Medicaid-funded births with short inter-birth intervals will decrease

Table 1 shows the evaluation design for the EFP component of the Demonstration. For each of the above hypotheses that were shown, the table shows:

- Data Source(s)
- Measure

- Periodicity
- Whether there will be a sample or not

**Table 1**

**Overview of EFP Evaluation Design**

Hypothesis	Data Source	Measure	Periodicity	Sample?
The rate of Medicaid-funded births for women eligible for the Demonstration will decrease	Encounter Data System	Births per 1,000 women aged 15-44 enrolled in the Demonstration	Annually	No
The percentage of Medicaid-funded births with short inter-birth intervals will decrease	Vital Statistics Birth File	Percent of women on Medicaid waiting at least 18 months between births	Annually	No

With respect to the first hypothesis above, on June 27, 2008 the State submitted to CMS a draft base year fertility rate methodology required by Paragraph 35(c) of the June 18, 2008 STCs. This is the basis for the State’s required calculation of “averted births.” In that document, the Base Year 1994 fertility rate was determined as follows:

- 1) 
$$\frac{\text{Number of Births Paid by through the Demonstration} \times 1,000}{\text{Number of Medicaid-Eligible Women Aged 15-44 Enrolled in the Demonstration}}$$
- 2) 
$$\frac{4,305 \times 1,000}{31,405}$$
- 3) 137.1 = Births per 1,000 Women Aged 15-44 enrolled in the Demonstration

Thus, “averted births” will be reported annually to CMS from the Base Year 1994 using the fertility rate measure specified. It should be noted that fertility rates using the above measure have been reported to CMS annually since approximately 1998.

With respect to the second hypothesis, it should be noted that since the beginning of enrollment in the Demonstration in August 1994, the State has been reporting to CMS on the percentage of Medicaid-funded births as compared to employer-sponsored funded births that represented a short inter-birth interval (i.e., less than 18 months).

With respect to the other required elements of Paragraph 57(b) of the June 18, 2008 STCs, the State will do the following:

- **EFP Enrollment** – The State has been reporting enrollment in EFP to CMS on monthly, quarterly, and annual bases since 1994. The specific measure reported is the number of individuals for whom the State has made an EFP capitation payment to RIte

Care Health Plans. The source of this information is the MMIS. The State will continue reporting in this manner.

- **Family Planning Patients Receiving a Clinical Referral for Primary Care** – In the third year of the Demonstration extension period, the State will conduct a brief survey of a sample of women enrolled in EFP during the second year of the Demonstration extension period. It will be a simple random sample of these women, until a quota of 30 respondents has been attained. The focus of the survey will be on:
  - Whether, during the course of a family planning visit, the women received a clinical referral for primary care
  - If a clinical referral was received, to where the women was referred
  - Whether the women actually obtained subsequent primary care

State personnel will conduct the survey.