

**STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
PUBLIC NOTICE OF PROPOSED RULE-MAKING**

FEBRUARY 11, 2013

**PUBLIC NOTICE OF PROPOSED CATEGORY II CHANGE TO THE RHODE ISLAND
MEDICAID GLOBAL CONSUMER CHOICE WAIVER**

The RI Executive Office of Health and Human Services (EOHHS) is focused and committed to improving health care for all Rhode Islanders, in particular our most vulnerable citizens. People with both Medicare and Medicaid are some of the most chronically ill and socially isolated citizens in our state. With Medicare covering some services and Medicaid covering others, both through fee-for-service delivery systems, there is little to no coordination of care, while navigating the system proves extremely difficult for those consumers. The Affordable Care Act provides the states an opportunity to improve the coordination of services for these consumers through managed care and primary care case management arrangements. The purpose of this filing is to notify all Interested Parties of upcoming program changes to include all Medicaid benefits, including long-term services and supports, into managed care programs, for all Medicaid members, including those also eligible for Medicare.

Beginning in September 1, 2013, EOHHS will enroll all Medicaid members, including Medicare and Medicaid eligibles (MMEs) into a managed care organization (MCO) or a primary care case management program (PCCM). These members will receive a notice from EOHHS explaining the changes and informing them of their ability to choose between an MCO or PCCM through which all of their Medicaid covered services, including long-term services and supports (LTSS), will be coordinated and reimbursed. LTSS includes nursing home care as well as home and community-based supports that allow members to live independently in the community. Medicare services will continue to be administered by the Medicare program in calendar year 2013. Members will be asked to choose one of these options within thirty days of receiving their notice. Members who do not make a choice will be auto-enrolled into one of these two programs; however, they will have the ability to switch between programs. EOHHS has submitted a Category II Global Waiver Change Request to CMS in order to secure federal authority for this change. Additionally, EOHHS is in discussion with CMS to develop a three-way contract between the state, CMS, and managed care organizations, so that eventually, the entire scope of both Medicare and Medicaid benefits can be delivered through the MCO. The anticipated implementation target date is January 2014. EOHHS refers to both of these new models as the Integrated Care Initiative.

This proposed Category II Waiver request/rule is accessible on the R.I. Secretary of State website (<http://www.sec.state.ri.us/ProposedRules/>) and the EOHHS website (www.ohhs.ri.gov) or available in hard copy upon request (401 462-2018 or RI Relay, dial 711). Interested persons should submit data, views or written comments by Wednesday, March 13, 2013 to Kimberly Merolla-Brito, Office of Policy Development, RI Department of Human Services, Louis Pasteur Building, 57 Howard Avenue Fl # 1, Cranston, RI 02920.

In Accordance with RIGL 42-35-3, an oral hearing will be granted if requested by twenty-five (25) persons, by an agency or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within thirty (30) days of this notice.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief or handicap in acceptance for or provision of services or employment in its programs or activities.



**RHODE ISLAND GLOBAL CONSUMER CHOICE COMPACT WAIVER
PROJECT NUMBER 11W-0024242/1**

CATEGORY II CHANGE
Request Number: 13-01-CII

Date of Request:	January 23, 2013
Proposed Implementation Date: <i>(45 day notice required)</i>	June 1, 2013

Fiscal Impact

	FFY 2013 (7 mos.)	FFY 2014 (12 mos.)
State:		
Federal: *FMAP calculated @ 51.48% in 2013 & 2014		
Total		

Description of Change:

Attachment A

Assurances:

Attachment B

Standard Funding Questions:

Attachment C

ATTACHMENT A: DESCRIPTION OF CHANGE

The Rhode Island Executive Office of Health and Human Services (EOHHS), (Rhode Island Medicaid) is submitting a change request to the Rhode Island Global Choice Compact Waiver, with an effective date of September 1, 2013 to mandatorily enroll Medicaid-only adults with disabilities and elders, and Medicare-Medicaid eligibles (MMEs) into a managed care delivery system for all acute, primary, behavioral health and long-term services and supports benefits. This request impacts only Medicaid benefits. State statutory authority for this change request was provided in the Rhode Island state budget for fiscal year 2012. Rhode Island Medicaid is requesting this approval under existing 1115 waiver authority of freedom of choice.

In addition, Rhode Island is requesting a change to existing 1115 waiver authority for amount, duration and scope, to include cost-effective alternative services to managed care enrollees, as a covered service, and eligible for federal matching payments.

This change is submitted as a Category II submission.

I. Background

Among the many health care issues facing the state today is how to improve the disjointed system for financing and delivering care to two of the most vulnerable populations the Medicaid program covers – Adults with Disabilities and Elders. Many of these beneficiaries have multiple chronic conditions and/or persistent behavioral health problems that require a mix of costly acute, sub-acute and long term services. Complicating matters, a large number of the beneficiaries in this group are eligible for both Medicare and Medicaid – “dual eligibles” – and must navigate the complex rules, requirements and payment schemes of two distinct programs to obtain the full range of services necessary to meet their care needs.

In July 2011, the RI General Assembly also recognized the importance of improving the system serving these beneficiaries:

By joint resolution pursuant to Rhode Island General Laws relating to the Medicaid Reform Act; Section 3 of Article 16: Integration of Care and Financing for Medicare and Medicaid Beneficiaries, the Executive Office of Health and Human Services (EOHHS) is directed to engage in a contractual arrangement for the expansion and integration of care management strategies by July of 2012 for Medicaid-only beneficiaries and beneficiaries dually eligible for Medicaid and Medicare.

Toward this end, this state issued a report¹ that focuses on the options for improving the way in which Medicaid eligible adults with disabilities and elders access health care services and long-term services and supports. Medicaid eligible adults with disabilities and elders represent about one quarter of the total RI Medicaid population, and just over 60 percent of total annual program expenditures. Although the service needs of adults with disabilities and elders do vary, the two populations share many common features. The beneficiaries in both groups tend to have very low incomes and limited assets. Many of these beneficiaries have multiple chronic conditions, one or more of which may result in a hospitalization or a nursing facility stay, which require a mix of acute, sub-acute and long term care services. These services are often fragmented and difficult to navigate.

¹ This report, *Integration of Care and Financing for Medicare and Medicaid Beneficiaries*, was posted to the EOHHS website on April 24, 2012

EOHHS intends to improve care for Medicaid-only and Medicare-Medicaid eligibles (MMEs) by achieving integration of acute care, primary care, and long-term care services for as many segments of the population of adults with disabilities and elders as is feasible given the constraints noted earlier in the report. Currently, all non-duals in this population are enrolled in either Rhody Health Partners or Connect Care Choice for their acute, primary and behavioral health care benefits. The state will build on these programs and provide a capitated risk-based option and an enhanced Primary Care Case Management (PCCM) option, to integrate acute, primary and long-term care services for Medicaid-only and MME members with a target start date of September 1, 2013, pending approval from CMS.

II. Eligible Populations

Eligibility for participation in the managed LTSS delivery system options are as follows:

- Medicaid-only individuals currently enrolled in Rhody Health Partners (RHP) or Connect Care Choice (CCC), who utilize community-based long-term services and supports
- Medicaid-only individuals who were disenrolled from RHP, CCC or RItE Care because they became permanent nursing home residents
- MMEs who were disenrolled from RHP or CCC because of their dual status
- Medically Needy MMEs who reside in nursing facilities
- Categorically eligible Medicare and Medicaid Eligible (MME) members who fall into the following groups:
 - MMEs residing in the community who are not currently utilizing long-term services and supports
 - MMEs in need of long-term services and supports (community or nursing home)
 - MMEs who receive their Medicare benefit through a Medicare Advantage Plan

Note: Spend-down clients are eligible for enrollment in Connect Care Choice Community Partners, but not in Rhody Health Options.

Excluded from participation in the managed LTSS delivery systems are:

- Partial duals, including Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs) and Qualified Individuals (QIs)
- Partial Medicare beneficiaries – Medicaid clients who only have Part A or only have Part B/D
- MMEs residing at Eleanor Slater Hospital
- MMEs residing at Tavares Pediatric Center
- MMEs who are currently incarcerated (i.e. adjudicated prisoners)
- MMEs who are in hospice/end-of-life care at the time enrollment occurs²

To minimize the confusion for families and beneficiaries in end-of-life care, these clients are exempt from initial enrollment. Members receiving hospice and their families face many difficult decisions during their time in care, and EOHHS does not intend to put any additional burden on these families. Eleanor Slater Hospital (ESH) treats patients with acute and long term medical illnesses as well as patients with psychiatric disorders. Most of the patients are admitted from community hospitals or other health care facilities and require hospital level long term care. The majority of patients at ESH are

² Once enrolled, members in need of hospice/end of life care, will remain enrolled

permanently institutionalized, with little to no potential for transition to the community. Tavares Pediatric Center is an ICF-MR level of care hospital for children. This facility has 21 beds, and is home to children with severe and profound disabilities, who are unable to be cared for in a home setting. There are some adults who reside at Tavares, because they were admitted during childhood and “aged in place”. These clients are permanently institutionalized, with little to no potential for transition to the community. Children who reside at Tavares are exempt from RIte Care enrollment, and those who age into adulthood are therefore exempt from managed care enrollment in Rhody Health Partners or Rhody Health Options.

III. Program Description

In the design of these two managed care models, EOHHS strove to preserve choice for beneficiaries, and to preserve provider-patient relationships. All Medicaid-only and MME members will be able to choose between the two program options, and will be able to switch options every month. EOHHS is not proposing a lock-in as part of this waiver change request. These two new program options will not reduce Medicaid benefits to members.

Option #1: Enhanced Primary Care Case Management (PCCM) Models – Connect Care Choice Community Partners (CCCCP)

The enhanced PCCM Model builds on the Connect Care Choice (CCC) Program’s demonstrated capacity and experience with the care needs of medically complex individuals. Currently, 17 CCC practice sites, meeting standards of performance adopted from the chronic care model of “best practices”, serve approximately 1,800 non-dual beneficiaries across Rhode Island. The CCC model encompasses primary care/nurse case management teams and co-located behavioral health to provide quality focused and holistic care to beneficiaries. CCC is designed to achieve and preserve access to primary, preventive, behavioral health and specialty care that allows the individual to remain well and independent in the community and decrease unnecessary acute episodes of care.

To address the needs for greater integration of primary care, acute care and long-term care services and for high touch care management, a bundled service contract will be sought to build a Community Health Care Team (CHCT) that will focus on long-term care services and supports. This community based entity will have demonstrated expertise and the necessary tools to perform the care/ case management, care coordination, transition services, nursing facility inpatient management for non skilled care, social supports, housing, and transportation supports, and services integration functions in collaboration with the CCC practices. For non-duals, the Enhanced PCCM will be a direct expansion of the existing CCC program to include a sharper focus on long-term care services. For dual eligibles, the contracted entity will take core responsibility for ongoing care coordination and service integration, through the Community Health Team. This program will be operated under the direction of the Office of Community Programs within the RI Medicaid Program.

In this option, payments for Medicaid covered services will be made on a fee-for-service basis. Additionally, there will be no change in the process for referring clients for long-term services and supports. Services that currently require prior authorization by EOHHS, will continue to require that authorization. Services that currently do not require prior authorization will continue to be covered as they were prior to the change in delivery system.

At a future date to be determined, RI Medicaid may seek to define the advanced model of primary care established by the CCC program and the contracted Community Health Care Team as “health homes,” as defined by the ACA. Under the health homes program, the CCC practice and the Community Health

Care Team will be required to prevent illness, reduce wasteful fragmentation, and avert the need for unnecessary and costly emergency department visits, hospitalizations and institutionalizations. We anticipate that an estimated two to three thousand dual eligibles as well as approximately 2,000 Medicaid only eligible adults with disabilities or elders will choose this model.

Under the CCCC program, the strengths of CCC are combined with an enhanced capacity in care management and service integration across all service categories: acute, behavioral health and long-term care. This pathway preserves the core person-centered medical home aspect of CCC and builds on the established chronic care model of best practices.

Option#2: Capitated Model – Rhody Health Options

Phase I of Pathway #2 is the procurement for contracts with Medicaid Managed Care organizations for the full spectrum of Medicaid services (including LTSS) for Medicaid-eligible individuals, including those who also have Medicare coverage. These contracts will be effective on September 1, 2013, pending approval from CMS.

In this first phase of system redesign, we anticipate excluding two service areas from the integrated package of benefits: long-term care services for adults with developmental disabilities and behavioral health services for individuals with serious and persistent mental illnesses (SPMI). The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) just recently began implementing new systems of care for these beneficiaries. It is too soon to evaluate whether the service integration needs of beneficiaries have been addressed adequately by these initiatives. Note also that the majority of beneficiaries in these segments are dual eligibles. In Phase I, these Medicaid funded services will continue to be reimbursed on a fee-for-service basis.

The second phase of pathway #2, involves the State, CMS, and the managed care organizations (MCOs) entering into a three-way contract, in which the MCOs receive a prospective blended payment to provide comprehensive, coordinated care to Rhode Island's dually eligible individuals. In a State Medicaid Director's Letter dated July 8, 2011, CMS outlined this opportunity for states and established specific timeframes and deliverables that must be met in order to enter into the three-way contract. EOHHS submitted a demonstration proposal to CMS on May 31, 2012, and discussions concerning Phase II are ongoing with the CMS Office of Innovation.

Population	Current Medicaid Delivery System	Future Medicaid Delivery System (9/1/13)
Medicaid-only clients receiving LTSS at home	<ul style="list-style-type: none"> • Rhody Health Partners for acute and primary care, LTSS carved out to FFS • Connect Care Choice for acute and primary care. All services paid FFS. • PACE 	<ul style="list-style-type: none"> • Rhody Health Options • Connect Care Choice Community Partners • PACE
Medicaid-only clients receiving LTSS in a nursing home	<ul style="list-style-type: none"> • Fee-for-service • PACE 	<ul style="list-style-type: none"> • Rhody Health Options • Connect Care Choice Community Partners • PACE
MMEs residing in a nursing home or	<ul style="list-style-type: none"> • Fee-for service • PACE 	<ul style="list-style-type: none"> • Rhody Health Options • Connect Care Choice

Population	Current Medicaid Delivery System	Future Medicaid Delivery System (9/1/13)
receiving LTSS at home		Community Partners • PACE
MMEs residing in the community, no LTSS	Fee-for-service	• Rhody Health Options • Connect Care Choice Community Partners • PACE

IV. Enrollment Phases and Auto-Assignment

Two months prior to enrollment effective date, Medicaid-only members and MMEs would be sent a communication via US Mail that informs them of their choice between Rhody Health Options or CCC Community Partners (CCCCP). Members will be provided a deadline to indicate their choice, and a phone number to call to exercise their preference. Staffing for this hotline will be from trained customer service professionals who are experienced with non-biased enrollment counseling.

If members do not call with their preference by the deadline indicated in the letter, the member will be auto-assigned to one of the two programs. Members may switch between the two programs on a monthly basis. Clients who are in RHP and receiving LTSS at the time the integrated care initiative becomes effective, will transition from RHP to Rhody Health Options. Clients who are in CCC and receiving LTSS at the time the integrated care initiative becomes effective, will transition from CCC to CCCC.

EOHHS' approach to auto-assignment will emphasize preserving existing provider-patient relationships. The first step in auto-assignment is using the Medicare primary care attribution method, to determine if an MME receives primary care from one of the 17 existing Connect Care Choice provider sites. Preliminary analysis using this methodology indicates there were approximately 5000 MME who receive primary care from one of those sites. EOHHS is assuming that the participating Health Plans will also have those sites as part of their primary care provider (PCP) network. Therefore, EOHHS will not assign all 5000 MMEs to CCCC. Instead, a 75/25 approach will be taken. Meaning that seventy-five percent (75%) of the site's MMEs will be auto-assigned to CCCC, and twenty-five percent (25%) of the sites MMEs will be auto-assigned to a participating Rhody Health Options plan. This 75/25 auto-assignment will be random in nature.

All remaining Medicaid-only and MME clients will be sent a letter indicating that they have been auto-assigned to one of the participating Rhody Health Options Health Plans. The auto-assignment to a Health Plan will be equal and random, but will take into account the following:

- If historical utilization data is available for primary care, and a member's primary care provider (PCP) is participating in one of the participating Health Plans' networks, auto-assignment will be made to that Health Plan.
- If an eligible member resides in a household with a RItE Care or Rhody Health Partners member(s), that member will be assigned to the same Health Plan as the RItE Care/RHP member, if that Health Plan is selected for the Phase I Integrated Care Initiative.
- If an eligible member was previously enrolled in RItE Care or Rhody Health Partners or CCC, and was disenrolled because of dual status or nursing home residence, auto-assignment will be to

the last known CCC Site or Health Plan the member was enrolled in, if that Health Plan is participating in the first Phase of ICI.

All members will be given the opportunity to change their auto-assigned Health Plan or to enroll in the CCC program if they choose to, within a six-week period.

After the program start date, to enroll newly eligible members, the State will make a “sweep” of all new eligible recipients, monthly. They will also be auto-assigned to a Health Plan based on the criteria cited above and a letter which will be sent to them two months prior to their enrollment date. These members will have a six-week period to change their auto-assignment. However, a member can choose to change between Rhody Health Options and *CCCCP* on a monthly basis (and vice versa). Members cannot however opt-out to fee-for-service (FFS) Medicaid.

A consolidated Member Services call center team will be created to answer incoming calls and to implement or make changes in the Health Plan and PCCM assignments and to provide information about the PACE option.

Enrollment will occur in four phases, over four months, using the schedule in the table below.

Mailing Date	Enrollment Date	Populations Included	Estimated # of Enrollees
1-Jul-13	1-Sep-13	Prior enrolled RIte Care, RHP and CCC member, disenrolled because of dual status or nursing home resident	1800
1-Aug-13	1-Oct-13	<ul style="list-style-type: none"> All Nursing Home residents 1/3 of community non-LTSS clients 	4,469 LTC 4,577 community
1-Sep-13	1-Nov-13	<ul style="list-style-type: none"> Home and community-based waiver clients 1/3 of community non-LTSS clients 	4,578 community 2,975 waiver
1-Oct-13	1-Dec-13	<ul style="list-style-type: none"> Clients with DD Clients with SPMI Remaining Community non-LTSS clients 	4,577 community 2,861 SPMI 2,248 MR/DD

V. Stakeholder Engagement

EOHHS had made and will continue to make significant efforts to involve and inform stakeholders in this delivery system redesign effort. EOHHS maintains an email list-serve of more than 500 stakeholders, and uses that email to inform stakeholders of public meetings, new documents on the website, and updates on the time line for implementation. Over the summer, EOHHS conducted an intensive stakeholder workgroup process.

From July 9, 2012 – August 10, 2012, EOHHS offered a series of workgroup meetings which met three times over this five week period. Each workgroup covered topics selected as imperative to the planning,

development, implementation, and monitoring of the Integrated Care Initiative. Each workgroup meeting was co-facilitated by topic experts from the community as well as an EOHHS representative. The three topic areas were:

- Outreach and Information
 - This workgroup provided recommendations for a strategy to facilitate and build successful relationships with the member and provider community through increased awareness and engagement, recommended a process to disseminate communications to those stakeholders and keep them connected and informed in an ongoing manner.
- Services and Supports
 - This workgroup provided recommendations for defining the necessary requirements for creating a comprehensive provider network to address health care needs including but not limited to acute care, specialty, long term services and supports and behavioral health; assisted EOHHS to define appropriate requirements for a responsive care management program (i.e. care models), and recommended alternative benefits that may assist in keeping people healthy and residing in the community.
- Oversight, Evaluation, and Continuous Improvement
 - This workgroup provided recommendations for determining the appropriate quality performance measures for individuals enrolled in the program to monitor outcomes; and assisted in developing a process for oversight, evaluation, and continuous quality improvement.

Each workgroup was open to any stakeholder and community member. Recommendations from the workgroups advised EOHHS' development of procurement documents for the procurement of CCCC and Rhody Health Options. Approximately 50 people participated in each workgroup. All materials from the workgroup, as well as summary recommendations documents, are available at <http://www.ohhs.ri.gov>.

EOHHS continued with stakeholder meetings in the fall, by hosting two open forums focused on the current long-term services and supports programs funded and managed by Medicaid. The purpose of these open forums was to inform consumers, providers, advocates and potential bidders, of the current service delivery system. Approximately 100 people attended each open forum.

In addition to client mailings and the enrollment hotline, EOHHS is conducting "train the trainer" sessions with community based organizations that provide direct services to members or provide informal supports to members. These organizations will assist EOHHS in informing members about these delivery system changes. EOHHS has begun and will continue to conduct open public meetings and targeted stakeholder meetings with providers, advocacy organizations, and other community groups to increase awareness of the program and inform consumers.

VI. Compliance with the Special Terms and Conditions

Under the existing 1115 Special Terms and Conditions sections related to Freedom of Choice (waiver of Section 1902(a)(23)), the state is seeking to amend this section in order to include individuals eligible for Medicare and Medicaid (MMEs) as a mandatory enrollment population for Rhody Health Options (RHO) or Connect Care Choice Community Partners(CCCCP).

EOHHS will not be reducing or altering the benefits currently authorized in the 1115 Special Terms and Conditions as a function of this program redesign. This request only impacts Medicaid benefits.

Tribal Notification

Per federal requirements, EOHHS notified the Narragansett Indian Tribe of this impending program change via letter and email on September 12, 2012. In addition, EOHHS will forward the final Category II change request to the tribe through the Interested Parties email notification process. The tribe is an important stakeholder, and EOHHS will make every effort to meet with tribal leaders individually to discuss this initiative.

Member Protections

Several member protections will be in place in order to ensure a smooth transition from fee-for service to a managed care program. The transition requirements listed below will be included in the contract with the MCOs for Rhody Health Options.

- Members will have the ability to change MCOs or programs each month – there is no lock-in for these programs.
- Access to out-of-network providers for six (6) months
- MCO will honor all prior authorizations from EOHHS for the period of the authorization, and with the provider whom received the authorization. This would include LTSS authorizations.
- Members residing in non-network nursing homes at the time of enrollment will remain in the non-network nursing homes, unless the member chooses to change nursing homes.

Access Standards

All the current access standards for Medicaid covered services will remain in effect. In addition, EOHHS will develop new access standards for LTSS home-based services.

Quality Strategy

EOHHS will amend the Global Waiver quality strategy to include clients receiving LTSS as well as Medicare/Medicaid eligible (MMEs).

ATTACHMENT B: ASSURANCES

Rhode Island Medicaid assures that the change is consistent with the Protections to Health and Welfare as Appropriate to Title XIX.

The State assures the following:

- This change is consistent with the protections to health and welfare as appropriate to title XIX of the Social Security Act (the Act) in accordance with 42 CFR 441-302, the State assures CMS that necessary safeguards will be taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
 - Adequate standards for all types of providers that furnish services under this Category II Change to the waiver will be met, including adequate training and supervision of providers.
 - The standards of any State licensure or certification requirement will be met for services or for individuals furnishing services that are provided under this Category II Change to the waiver. The State assures that these requirements will be met on the date that the services are furnished.
 - All beneficiary rights and protections will be accorded including the right to a fair hearing.
- The change results in appropriate efficient and effective operation of the program, Including Justification and Response to Funding Questions
- This change would be permissible as a State Plan or Section 1915 Waiver Amendment and is otherwise consistent with sections 1902, 1903, 1905, and 1906, Current Federal Regulations and CMS Policy.

ATTACHMENT C: STANDARD FUNDING QUESTIONS

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Providers receive and retain the total Medicaid expenditures claimed by the State. No portion of the payments is returned to the State, local governmental entity, or any other intermediary organization.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation were not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the nonfederal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
 - (i) a complete list of the names of entities transferring or certifying funds;
 - (ii) the operational nature of the entity (state, county, city, other);
 - (iii) the total amounts transferred or certified by each entity;
 - (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
 - (v) whether the certifying or transferring entity received appropriations
(identify level of appropriations)

The State share is funded through general revenue funds appropriated by the

legislature for this purpose.

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

No supplemental or enhanced payments are made.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

N/A

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

No governmental providers receive payments that in the aggregate exceed their reasonable costs of providing services.