

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00242/1

TITLE: Rhode Island Comprehensive Demonstration

AWARDEE: Rhode Island Executive Office of Health and Human Services

Title XIX Waivers

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration extension project beginning as of December 23, 2013, through December 31, 2018. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

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

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

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

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

To enable the state to impose waiting periods for home and community-based services (HCBS) waiver-like long term care services.

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

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

4. Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to restrict freedom of choice of provider for individuals in the demonstration. No waiver of freedom of choice is authorized for family planning providers.

Rhode Island Comprehensive Demonstration
Demonstration Approval Period: December 23, 2013 through December 31, 2018
Amended September 24, 2018

5. Retroactive Eligibility

Section 1902(a)(34)

To enable the state to exclude individuals in the demonstration from receiving coverage for up to 3 months prior to the date that an application for assistance is made.
The waiver of retroactive eligibility does not apply to individuals under section 1902(l)(4)(A) of the Act.

6. Payment for Self-Directed Care

Section 1902(a)(32)

To permit the state to operate programs for individual beneficiaries to self-direct expenditures for long-term care services.

7. Payment Review

Section 1902(a)(37)(B)

To the extent that the state would otherwise need to perform prepayment review for expenditures under programs for self-directed care by individual beneficiaries.

8. Proper and Efficient Administration

Section 1902(a)(4)

To permit the State to enter into contracts with a single Prepaid Ambulatory Health Plan (PAHP) for the delivery of dental services under the RItSmiles Program without regard to the choice requirements of 42 C.F.R. § 438.52

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00242/1

TITLE: Rhode Island Comprehensive Demonstration

AWARDEE: Rhode Island Executive Office of Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Rhode Island for items identified below, which are not otherwise included as matchable expenditures under section 1903 of the Act shall, for the period of this demonstration beginning December 23, 2013 through December 31, 2018, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Rhode Island (the state) to operate its section 1115 Medicaid demonstration. These expenditure authorities promote the objectives of title XIX in the following ways:

1. Increase access to, stabilize, and strengthen, providers and provider networks available to serve Medicaid and low-income populations in the state
2. Improve health outcomes for Medicaid and other low-income populations in the state
3. Increase efficiency and quality of care through initiatives to transform service delivery networks

1. Expenditures Related to Eligibility Expansion

Expenditures to provide medical assistance coverage to the following demonstration populations, who meet applicable citizenship and identity requirements, that are not covered under the Medicaid state plan and are enrolled in the Rhode Island Comprehensive demonstration.

[Note: Budget populations 1, 2, 4, 14, and 22, which are described in the demonstration's special terms and conditions and are affected by the demonstration, are covered under the Medicaid state plan. Demonstration populations 11 – 13 (related to 217-like groups) are described in expenditure authority 2 below, and demonstration population 7 is described in CHIP expenditure authority 1 below.]

Budget Population 3 [Rite Care]: Effective through December 31, 2013, expenditures for pregnant women with incomes up to 185 percent of the federal poverty level (FPL) and children whose family incomes are up to 250 percent of the FPL who are not otherwise eligible under the

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

approved Medicaid state plan,.

Effective through December 31, 2013, expenditures for parents and caretaker relatives who are not otherwise eligible under the approved Medicaid state plan with incomes that is up to 175 percent of the FPL.

Effective January 1, 2014, expenditures for pregnant women with incomes up to 185 percent of the federal poverty level (FPL) and children whose family incomes are up to 250 percent of the FPL who are not otherwise eligible under the approved Medicaid state plan.

Budget Population 5 [EFP]: Effective through December 31, 2013, expenditures for family planning services under the Extended Family Planning (EFP) program, for women of childbearing age whose family income is at or below 200 percent of the FPL who lose Medicaid eligibility at the conclusion of their 60-day postpartum period and who do not have access to creditable health insurance. Continued program eligibility for these women will be determined by the twelfth month after their enrollment in the program.

Effective January 1, 2014, expenditures for family planning services under the Extended Family Planning program, for women of childbearing age whose family income is at or below 250 percent of the FPL who lose Medicaid eligibility at the conclusion of their 60-day postpartum period. Continued program eligibility for these women will be determined by the twelfth month after their enrollment in the program.

Budget Population 6a [Pregnant Expansion]: Individuals who, at the time of initial application: (a) are uninsured pregnant women; (b) have no other coverage; (c) have net family incomes between 185 and 250 percent of the FPL; (d) receive benefits only by virtue of the Comprehensive demonstration; (e) meet the citizenship and identity requirements specified in the Deficit Reduction Act of 2005; and f) are covered using title XIX funds if title XXI funds are exhausted.

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

Budget Population 8 [Substitute Care]: Expenditures for parents pursuing behavioral health treatment with children temporarily in state custody with income up to 200 percent of the FPL.

Budget Population 9 [Children with special health care needs (CSHCN) Alt.]: Expenditures for CSHCN (as an eligibility factor) who are 21 and under who would otherwise be placed in voluntary state custody below 300 percent SSI.

Budget Population 10 [Elders 65 and over]: Effective through December 31, 2013, expenditure authority for those at risk for needing long term care (LTC) with income at or below 200 percent of the FPL.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

Effective January 1, 2014, expenditure authority for those at risk for needing LTC with income at or below 250 percent of the FPL who are in need of home and community-based services.

Budget Population 15 [Adults with disabilities at risk for long-term care]: Expenditures for HCBS waiver like services for adults living with disabilities with incomes at or below 300 percent of the SSI with income and resource levels above the Medicaid limits.

Budget Population 16 [Uninsured adults with mental illness]: Effective through December 31, 2013, expenditures for a limited benefit package of supplemental services for uninsured adults with mental illness and/or substance abuse problems with incomes below 200 percent of the FPL not eligible for Medicaid.

Budget Population 17 [Youth at risk for Medicaid]: Expenditures for coverage of detection and intervention services for at-risk young children not eligible for Medicaid who have incomes up to 300 percent of SSI, including those with special health care needs, such as Seriously Emotionally Disturbed (SED), behavioral challenges and/or medically dependent conditions, who may be safely maintained at home with appropriate levels of care, including specialized respite services.

Budget Population 18 [HIV]: Effective through December 31, 2013, expenditures for a limited benefit package of supplemental HIV services for persons living with HIV with incomes below 200 percent of the FPL, and who are ineligible for Medicaid.

Budget Population 19 [Non-working disabled adults]: Effective through December 31, 2013, expenditures for a limited benefit package of supplemental services for non-working disabled adults ages 19-64 eligible for the General Public cash assistance program, but who do not qualify for disability benefits.

Budget Population 20 [Alzheimer adults]: Effective January 1, 2014, expenditure authority for adults aged 19-64 who have been diagnosed with Alzheimer's Disease or a related Dementia as determined by a physician, who are at risk for LTC admission, who are in need of home and community care services, whose income is at or below 250 percent of the FPL.

Budget Population 21 [Beckett aged out]: Effective January 1, 2014, expenditure authority for young adults aged 19-21 aging out of the Katie Beckett eligibility group with incomes below 250 percent of the FPL, who are otherwise ineligible for Medicaid, are in need of services and/or treatment for behavioral health, medical or developmental diagnoses.

2. Expenditures Related to Eligibility Expansion for 217-like groups.

Expenditures for Comprehensive demonstration beneficiaries who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the Comprehensive demonstration Rhode Island Comprehensive Demonstration
Demonstration Approval Period: December 23, 2013 through December 31, 2018
Amended September 24, 2018

were provided under an HCBS waiver granted to the state under section 1915(c) of the Act. This includes the application of spousal impoverishment eligibility rules.

Budget Population 11: Expenditures for 217-like Categorically Needy Individuals receiving HCBS-like services & PACE-like participants Highest need group.

Budget Population 12: Expenditures for 217-like Categorically Needy Individuals receiving HCBW-like services and PACE-like participants in the High need group.

Budget Population 13: Expenditures for 217-like Medically Needy receiving HCBW-like services in the community (High and Highest group). Medically Needy PACE-like participants in the community.

3. Health System Transformation Project-Accountable Entity Incentive and Hospital and Nursing Home Incentive

Expenditures for performance based incentive payments to providers who participate in the Hospital and Nursing Home Incentive Program and to providers who participate as a certified Accountable Entity, subject to the annual expenditure limits set forth in the STCs.

4. Window Replacement [Budget Services 1]: Expenditures for window replacement for homes which are the primary residence of eligible children who are lead poisoned.

5. RItE Share [Budget Services 2].

Expenditures for part or all of the cost of private insurance premiums and cost sharing for eligible individuals which are determined to be cost-effective using state-developed tests that may differ from otherwise applicable tests for cost-effectiveness.

6. Designated State Health Program (DSHP)

Budget Population 23: Expenditures for cost of designated programs that provide or support the provision of health services that are otherwise state-funded, as specified in STC 81.

a. **Marketplace Subsidy Program:** Effective January 1, 2014, the state may claim as allowable expenditures under the demonstration, the payments made through its state-funded program to provide premium subsidies for parents and caretakers with incomes above 133 percent of the FPL through 175 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is above 133 percent of the FPL through 175 percent of the FPL.

b. **State-Funded Program for Uninsured Adults with Mental Illness:** Effective January 1, 2014 through April 30, 2014, expenditures for a state-funded program that provides a limited benefit

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

package of supplemental services for uninsured adults with mental illness and/or substance abuse problems with incomes below 200 percent of the FPL.

Effective May 1, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental services for uninsured adults with mental illness and/or substance abuse problems with incomes above 133 percent of the FPL and below 200 percent of the FPL who are ineligible for Medicaid.

- c. **State-Funded Program for Persons Living with HIV:** Effective January 1, 2014 through April 30, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental HIV services for persons living with HIV with incomes below 200 percent of the FPL.

Effective May 1, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental HIV services for persons living with HIV with incomes above 133 percent of the FPL and below 200 percent of the FPL who are ineligible for Medicaid.

- d. **State-Funded Program for Non-working Disabled Adults:** Effective January 1, 2014 through April 30, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental services for non-working disabled adults ages 19-64 eligible for the General Public cash assistance program.

Effective May 1, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental services for non-working disabled adults ages 19-64 eligible for the General Public cash assistance program with incomes above 133 percent of the FPL, but who do not qualify for disability benefits.

7. Demonstration Benefits.

- a. Expenditures for benefits specified in Attachment A of the STCs provided to demonstration populations, which are not otherwise available in the Medicaid State Plan.
- b. Expenditures for the provision of HCBS waiver-like services that are not otherwise available under the approved State plan, net of beneficiary post-eligibility responsibility for the cost of care.
- c. Expenditures for core and preventive services for Medicaid eligible at risk youth (Budget Services 4).

- 8. **End of Month Coverage for Members Transitioning to Subsidized Qualified Health Plan (QHP) Coverage.** Effective January 1, 2014, expenditures for individuals who would otherwise lose Medicaid eligibility pending coverage in a QHP, as specified in STC 27.

9. Expenditures for Healthy Behaviors Incentives.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

10. Long-Term Care Benefits Pending Verification of Financial Eligibility Criteria for New LTC Applicants. Expenditures for a limited set of LTC benefits for individuals who self-attest to financial eligibility factors as specified in STC 28.

11. Expenditures for Recovery Navigation Program. Expenditures to deliver a recovery-oriented environment and care plan dedicated to connecting individuals with a substance use disorder eligible for RNP services as specified in STC 94, with the necessary level of detox, treatment, and recovery services within a less-intensive and less-costly level of care than is furnished in an inpatient hospital setting.

12. Expenditures for Peer Recovery Specialists.

Expenditures to deliver services using a Peer Recovery Specialist (PRS) who provides an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connections to the community, as well as offer services, as outlined in STC 104, that will focus on the treatment of mental health and/or substance use disorders for those individuals who have trouble stabilizing in the community and/or are in need of supports to maintain their stability in the community.

Title XIX Requirements Not Applicable to Budget Population 5:

Amount, Duration, and Scope

Section 1902(a)(10)(B)

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

Title XIX Requirements Not Applicable to Budget Populations 10, 15, 16, 17, 18, 19, 20

Amount, Duration, and Scope

Section 1902(a)(10)(B)

To enable Rhode Island to provide a limited benefit package.

CHIP Expenditure Authority

1. Expenditures for medical assistance for children through age 18 whose family income is equal to or less than 250 percent of the FPL and who are not otherwise eligible under the approved Medicaid state plan. [Budget Population 7]

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00242/1

TITLE: Rhode Island Comprehensive Section 1115 Demonstration

AWARDEE: Rhode Island Executive Office of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Rhode Island Comprehensive section 1115(a) Medicaid demonstration (the demonstration), as approved under authority of section 1115 of the Social Security Act (the Act). The parties to this agreement are the Rhode Island Executive Office of Health and Human Services (the state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The amended STCs are effective the date of approval, unless otherwise specified. All previously approved section 1115(a) demonstration STCs, waivers, and expenditure authorities are superseded by the STCs set forth below and accompanying waivers and expenditure authorities. All previously approved Category II changes , as stated in STC 18 shall apply during the extension period. This demonstration is approved through December 31, 2018.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Title XIX Program Flexibility
- V. Eligibility and Enrollment
- VI. Benefits
- VII. Cost Sharing
- VIII. Delivery System
- IX. Self-Direction
- X. Extended Family Planning
- XI. RIte Smiles
- XII. Designated State Health Programs (DSHP)

Rhode Island Comprehensive Demonstration
Demonstration Approval Period: December 23, 2013 through December 31, 2018
Amended September 24, 2018

- XIII. Healthy Behaviors Incentives Program
- XIV. Payments To Federally Qualified Health Centers For Uninsured Populations
- XV. General Reporting Requirements
- XVI. General Financial Requirements Under Title XIX
- XVII. General Financial Requirements Under Title XXI
- XVIII. Monitoring Budget Neutrality for the Demonstration
- XIX. Evaluation of the Demonstration / Quality Assurance and Improvement
- XX. Measurement of Quality of Care and Access to Care Improvement
- XXI. Schedule of Deliverables for the Demonstration Period

The following attachments have been included to provide supplemental information and guidance for specific STCs. The following attachments are incorporated as part of this Agreement.

- Attachment A: Managed Care Demonstration Only Benefits
- Attachment B: Core and Preventive Home and Community-based Service Definitions
- Attachment C: Assessment and Coordination Organization
- Attachment D: Level of Care Criteria
- Attachment E: Quarterly Report Progress Template and Instructions
- Attachment F: Evidentiary Review Guidance for Conducting Quality Reviews of HCBS Waiver Programs
- Attachment G: Comprehensive Quality Strategy (reserved)
- Attachment H: Healthy Behaviors Incentives Program Description (reserved)
- Attachment I: Evaluation Plan (reserved)
- Attachment J: Hospital and Nursing Home Facilities Measures
- Attachment K: Accountable Entities Certification Standards
- Attachment L: Total Cost of Care and Incentive Program Requirements Document
- Attachment M: Attribution Guidance
- Attachment N: Accountable Entity Road Map Document
- Attachment O: Accountable Entity- Specific Health Transformation Project Plan
- Attachment P: Claiming Protocol – Other DSHPs
- Attachment Q: Wavemaker Methodology and Claiming Protocol
- Attachment R: Health Workforce Development Protocol
- Attachment S: Claiming Protocol – Health Workforce Development
- Attachment T: Deliverables Chart – 5 Years
- Attachment U- RNP Claiming Methodology Protocol
- Attachment V- HOLD
- Attachment W- RNP- Memoranda of Agreements (MOA) Template
- Attachment X- RNP Approved EOHHS Screening Tool

Rhode Island Comprehensive Demonstration
Demonstration Approval Period: December 23, 2013 through December 31, 2018
Amended September 24, 2018

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Rhode Island Medicaid Reform Act of 2008 (R.I.G.L §42-12.4) directed the state to apply for a global demonstration project under the authority of section 1115(a) of Title XI of the Social Security Act (the Act) to restructure the state's Medicaid program to establish a "sustainable cost-effective, person-centered and opportunity driven program utilizing competitive and value-based purchasing to maximize available service options" and "a results-oriented system of coordinated care."

Toward this end, Rhode Island's Comprehensive demonstration establishes a new State-Federal compact that provides the State with substantially greater flexibility than is available under existing program guidelines. Rhode Island will use the additional flexibility afforded by the waiver to redesign the State's Medicaid program to provide cost-effective services that will ensure that beneficiaries receive the appropriate services in the least restrictive and most appropriate setting.

Under this demonstration, Rhode Island operates its entire Medicaid program subject to the financial limitations of this section 1115 demonstration project, with the exception of:

1) disproportionate share hospital (DSH) payments; 2) administrative expenses; 3) phased-Part D contributions; and 4) payments to local education agencies (LEA) for services that are furnished only in a school-based setting, and for which there is no third party payer.

With those four exceptions, 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, whether furnished under the approved state plan, or in accordance with waivers or expenditure authorities granted under this demonstration or otherwise, are subject to the requirements of the demonstration. Rhode Island's previous section 1115 demonstration programs, RItE Care and RItE Share, were subsumed under this demonstration, in addition to the state's previous section 1915(b) Dental Waiver and the state's previous section 1915(c) home and community-based services (HCBS) waivers.

The Rhode Island Comprehensive demonstration includes the following distinct components:

- a. The Managed Care component provides Medicaid state plan benefits as well as supplemental benefits as identified in Attachment A to most recipients eligible under the Medicaid state plan, including the new adult group effective January 1, 2014. Benefits are provided through comprehensive mandatory managed care delivery systems. The amount, duration and scope of these services may vary and limitations must be set out in the state plan, these STCs, or in demonstration changes implemented using the processes described in section IV of these STCs.
- b. The Extended Family Planning component provides access to family planning and referrals to primary care services for women whose family income is at or below 200 percent of the federal poverty level (FPL), and who lose Medicaid eligibility under RItE Care at the conclusion of their 60-day postpartum period. Effective January 1, 2014, eligibility will be raised to 250 percent of the FPL. See Section IX for more detailed requirements.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- c. The RItE Share premium assistance component enrolls individuals who are eligible for Medicaid/CHIP, and who are employees or dependents of an employee of an employer that offers a “qualified” plan into the ESI coverage.
- d. Effective through December 31, 2013, the Rhody Health Partners component provides Medicaid state plan and demonstration benefits through a managed care delivery system to aged, blind, and disabled beneficiaries who have no other health insurance. Effective November 1, 2013, the Rhody Health Options and Connect Care Choice Community Partners component will expand to all qualified aged, blind, and disabled beneficiaries whether they have other health insurance or not. Effective January 1, 2014, the New Adult Group will be enrolled in Rhody Health Partners. The amount, duration, and scope of these services may vary and limitations must be set out in the state plan, these STCs, or in demonstration changes implemented using the processes described in section IV of these STCs.
- e. The Connect Care Choice component provides Medicaid state plan benefits to aged, blind, and disabled beneficiaries who have no other health insurance, through a primary care case management system. The amount, duration, and scope of these services may vary and limitations must be set out in the state plan, these STCs, or in demonstration changes implemented using the processes described in section IV of these STCs.
- f. The Home and Community-Based Service component provides services similar to those authorized under sections 1915(c) and 1915(i) of the Act to individuals who need home and community based services either as an alternative to institutionalization or otherwise based on medical need.
- g. The RItE Smiles Program is a managed dental benefit program for Medicaid eligible children born after May 1, 2000.
- h. Rhody Health Options is a managed care delivery system for Medicaid only and Medicare Medicaid eligibles that integrates acute and primary care and long term care services and supports.
- i. Connect Care Choice Community Partners is an optional delivery system for Adult, Blind and Disabled Medicaid and Medicare Medicaid eligibles that utilizes a community health team and a Coordinating Care Entity to integrate Medicaid benefits.

In 2013, CMS renewed the Comprehensive demonstration through December 31, 2018. This renewal includes changes to support the state’s implementation of the Affordable Care Act (including coverage of the new adult group for adults with incomes at or below 133 percent of the FPL), the expansion of the state’s home and community based services (HCBS), and the conversion from an aggregate cap to a per member per month budget neutrality model.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

On October 20, 2016, CMS approved an amendment that provides for federal funding of designated state health programs (DSHPs) that promote healthcare workforce development to ensure access to trained healthcare professionals for eligible individuals. This DSHP funding will be phased down over the period of the demonstration, as the state develops alternative funding sources for these programs. The state submitted an amendment on May 17, 2016 that requested federal funding of DSHPs to ensure the continuation of workforce training and other vital health care programs while the state devotes increased state resources during the period of this demonstration to a “Health System Transformation Project” that will positively impact the Medicaid program. DSHP funding will be limited to the additional state funding attributable to the establishment of Accountable Care Entities through Medicaid managed care contracts, net of savings attributable to the operation of those entities and the costs associated with the Hospital and Nursing Home Incentive program as outlined in STC 46. The Accountable Entities (AEs) will be responsible for improving the quality of care, and there will be Alternative Payment models established, between MCO health plans and AEs through the development of value-based contracts. The amount of DSHP funding will be phased down over the period of the demonstration as the implementation costs associated with AEs diminish and savings resulting from their operations reduce funding needs.

On February 8, 2018, CMS approved the category III change request from the state to give Rhode Island the authority to create two new programs: Recovery Navigation Program (RNP) and Peer Recovery Specialist (PRS). These programs intend to offer services to Medicaid beneficiaries with certain chronic diseases and conditions. RNP is a recovery-oriented environment that will connect individuals with necessary resources such as detoxification treatments, care management, and/or other recovery services. The Peer Recovery Specialist (PRS) will be a credentialed health care professional who provides an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connections to the community.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Concurrent Operation.** The state’s title XIX state plan as approved; its title XXI state plan, as approved; and this Medicaid section 1115 demonstration entitled “Rhode Island Comprehensive Demonstration,” will continue to operate concurrently for the demonstration period.
- 2. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 3. Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

and expenditure authority documents of which these terms and conditions are part, must apply to the demonstration.

- 4. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
- 5. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
 - a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with the change. The modified agreements will be effective upon the implementation of the change.
 - b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day that the state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 6. State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for programmatic changes affecting populations who would not be eligible under the state plan as of November 1, 2008 (state plan populations). Nor will the state be required to submit state plan amendments for programmatic changes that affect other populations and are defined in STC 18 as Category I or Category II changes. The state will be required to submit either a state plan amendment or an amendment to the demonstration as applicable for Category III changes.

Changes relating to disproportionate share hospital (DSH) payments and coverage and payment of services furnished by local educational agencies (LEAs) require state plan amendments because these are excluded from the demonstration.

Rhode Island will be responsible for submitting state plan amendments to bring into compliance provisions of the current state plan that are inconsistent with Federal law or policy. The state must obtain CMS approval of any changes to payment methodology within the State Plan or this Medicaid section 1115 demonstration prior to any changes the state would like to implement.

- 7. Extension of the Demonstration.** If the state intends to request demonstration extensions under sections 1115(e) or 1115(f), the state must observe the timelines contained in those statute provisions. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of paragraph 8.

As part of the demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 14, as well as include the following supporting documentation:

- a. Demonstration Summary and Objectives. The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes requested along with the objective of the change and desired outcomes must be included.
- b. Special Terms and Conditions (STCs). The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address duplicate areas, the STCs need not be documented a second time.
- c. Waiver and Expenditure Authorities. The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
- d. Quality. The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.
- e. Compliance with the Budget Neutrality Agreement. The state must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In addition, the state must provide up-to-date responses to the CMS Financial Management standard questions.
- f. Draft on Evaluation Status and Findings. The state must provide a narrative summary of the evaluation design, status including evaluation activities and findings to date, and plans for evaluation activities during the expansion period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available. The state must report interim research and evaluation findings for key research questions as a condition of renewal.
- g. Compliance with Transparency Requirements at 42 CFR §431.412. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 14, as well as include the following supporting documentation:
 - i. *Demonstration Summary and Objectives*. The state must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future

goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

- ii. *Special Terms and Conditions.* The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
- iii. *Waiver and Expenditure Authorities.* The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
- iv. *Quality.* The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO), state quality assurance monitoring and quality improvement activities, and any other documentation of the quality of care provided under the demonstration.
- v. *Compliance with the Budget Neutrality.* The state must provide financial data (as set forth in the current STCs) demonstrating that the state has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of President's budget and historical trend rates at the time of the extension.
- vi. *Interim Evaluation Report.* The state must provide an evaluation report reflecting the hypotheses being tested and any results available.
- vii. *Demonstration of Public Notice 42 CFR §431.408.* The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 including the post-award public input process described in 42 CFR §431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

8. Demonstration Transition and Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

- b. Plan approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.
- c. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries including any individuals on demonstration waiting lists, and ensure ongoing coverage for those beneficiaries determined eligible for ongoing coverage, as well as any community outreach activities including community resources that are available. The state must adhere to waiting list requirements outlined in STC 34.
- d. Transition and Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR section 435.916.
- e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR section 431.416(g).
- f. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a. Expiration Requirements. The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- b. Expiration Procedures. The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.
 - c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR § 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
 - d. FFP. FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.
- 10. CMS Right to Amend, Terminate or Suspend for Cause.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
- 11. Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.
- 12. Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time that it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of titles XIX or XXI. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the demonstration, including services and administrative costs of disenrolling participants.
- 13. Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
- 14. Public Notice and Consultation with Interested Parties.** The state must continue to comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) for any category III program changes to the demonstration, including, but not limited to, those referenced in paragraph 18 of Section IV, Program Flexibility.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- 15. Post Award Forum.** Within six months of the demonstration’s implementation and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medicaid Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of the STC. The state must include a summary in the quarterly report, as specified in STC 114, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required by STC 115.
- 16. FFP.** No Federal administrative or service matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.
- 17. Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The State shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

IV. TITLE XIX PROGRAM FLEXIBILITY

Rhode Island has flexibility to make changes to its demonstration based on how the changes align with the categories defined below and the corresponding process in this Section paragraph 18, “Process for Changes to the Demonstration.” The categories of changes described below are for changes to the program as described in the STCs. Initiatives described in the STCs are approved upon approval of the demonstration.

- 18. Categories of Changes and General Requirements for Each Category.** When making changes, the state must characterize the change in one of the three following categories below. CMS has 15 business days after receiving notification of the change (either informally for Category I or formally for Categories II and III) to notify the state of an incorrect characterization of a programmatic change. To the extent the state and CMS are unable to reach mutual agreement on the characterization of the programmatic change, the CMS characterization shall be binding and non-appealable as to the procedure to be followed.
- 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 113 through 115. Implementation of these changes does not require approval by CMS.

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

- Changes to the instruments used to determine the level of care.
 - Changes to the Assessment and Coordination Organization Structure.
 - Changes to general operating procedures.
 - Changes to provider network methodologies (provider enrollment procedures, but not delivery system changes).
 - Changes to prior authorization procedures.
 - Adding any HCBS service that has a core definition in the Instructions/Technical Guidance under section 1915(c) if the state intends to use the core definition.
 - 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 (including adding populations to managed care), 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 state plan amendment public notice process prior to implementation. The state must also notify CMS in writing of Category II changes prior to implementation, and must furnish CMS with appropriate assurances and justification, that include, but are not limited to, the following:
- i. That the change is consistent with the protections to health and welfare as appropriate to title XIX of the Act, including justification;
 - ii. That the change results in appropriate efficient and effective operation of the program, including justification and response to funding questions;
 - iii. That the changes would be permissible as a state Plan or section 1915 waiver amendment; and that the change is otherwise consistent with sections 1902, 1903, 1905, and 1906 of the Act, current Federal regulations, and CMS policy; and
 - iv. Assessment of the cost of the change.

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/IDD, 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 Behaviors Incentives;
 - 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 benefit;
 - Benefit changes in accordance with the flexibility outlined in current Medicaid regulations, as amended on July 15, 2013 at 78 FR 42160 (and any subsequent amendments);
 - Cost-Sharing Changes up to the limits specified in Medicaid cost-sharing regulations published on July 15, 2013, unless otherwise defined in the STCs.
- c. Category III Change. Is a change requiring modifications to the current waiver or expenditure authorities including descriptive language within those authorities and the STCs, and any other change that is not clearly described within Categories I and II. In addition, a programmatic change may be categorized as a Category III change by the state to obtain reconsideration after unsuccessfully pursuing approval of the change under Category II. The state must comply with the section 1115 demonstration public notice process as described in paragraph 14 of these STCs. The state must notify CMS in writing of Category III changes, and submit an amendment to the demonstration as described in paragraph 19, “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 Medicaid cost-sharing flexibility (would exceed 5 percent of family income) in current Medicaid regulations;
- Benefit changes that are not in accordance with current Medicaid regulations; and
- Post-eligibility treatment of income; and
- Amendments requesting changes to the budget neutrality limits.

19. Process for Changes to the Demonstration. The state must submit the corresponding notification to CMS for any changes it makes to the demonstration as characterized in the Category I, II or III definitions section depending on the level of change. CMS will inform the state within 15 business days of any correction to the State’s characterization of a change, which shall be binding and non-

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

appealable as to the procedure for the change. The state must also have a public notice process as described below for Category II and III changes to the demonstration.

- a. Process for Category I Changes. The state must notify CMS of any change to the demonstration defined as a Category I change 30 calendar days before implementing the change. The state must also report these changes in the quarterly and annual reports for purposes of monitoring the demonstration. The state does not need CMS approval for changes to the demonstration that are Category I changes.

If CMS determines at any time subsequent to state implementation of a Category I change that it is not consistent with state assurances, or is contrary to Federal statutes, regulations, or CMS policy, CMS reserves the right to request prompt state corrective action as a condition of continued operation of the demonstration. If the state does not take appropriate action, CMS reserves the right to end the demonstration per Paragraph 10 of these STCs.

- b. Process for Category II Changes. The state will notify CMS of any change to the demonstration defined as a Category II change. This notification will include assurances that the change is consistent with Federal statutes, regulations, and CMS policy. No Federal funding shall be available for unapproved demonstration activities affected by a Category II change.

The state must submit the notification and assurances 45 calendar days prior to the date set by the state for implementing the change. CMS will not provide federal matching funds for unapproved Category II changes. After receipt of the State's written notification, CMS will notify the state:

- i. Within 45 calendar days of receipt if the assurances supporting the change are approved; or
- ii. Within 45 calendar days of receipt if the assurances do not establish that the change is consistent with federal statutes, regulations, and CMS policy. As part of the notification, CMS will describe the missing information, necessary corrective actions, and/or additional assurances the state must pursue to make the change consistent.
- iii. During days 46 and beyond, CMS will be available to work with the state. During this time period, the state can provide to CMS additional justification or assurance in order to clarify the appropriateness of the change.
- iv. During days 46 through 75, the state, upon taking appropriate action, must submit a written statement to CMS indicating how the state has addressed CMS concerns on the assurances. Within 15 calendar days of the date of the additional submission, CMS will notify the state if the assurances are approved.
- v. By day 90, if the assurances have not been approved by CMS, the state may obtain reconsideration by pursuing the change again as a revised Category II change if the state has additional information, or as a Category III change.
- vi. If CMS determines at any time subsequent to state implementation of an approved Category II change that the assurances are no longer valid, CMS shall request prompt state corrective action as a condition of continued operation of the demonstration.
- vii. After implementation, FFP is available for approved changes.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- c. Process for Category III Changes. The state must submit an amendment to the demonstration as defined in the paragraphs below.
- i. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval from CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph (ii) below. The state will notify CMS of proposed demonstration changes at the monthly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.
 - ii. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:
 1. An explanation of the public process used by the state consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;
 2. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
 3. An up-to-date CHIP Allotment Neutrality worksheet;
 4. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI state plan amendment if necessary; and
 5. A description of how the evaluation design will be modified to incorporate the amendment provisions.

V. ELIGIBILITY AND ENROLLMENT

20. Populations Affected and Eligible under the Demonstration.

The following populations listed on the tables below will receive coverage through the service delivery systems under the Comprehensive demonstration.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

Mandatory and optional Medicaid and/or CHIP state plan groups described in Table 1 below derive their eligibility through the Medicaid State Plan are subject to all applicable Medicaid laws and regulations except as expressly waived under authority granted by this demonstration. Those groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration, describe in Table 2 below, are subject to Medicaid and/or CHIP laws, regulations and policies except as expressly identified as not applicable under expenditure authority granted by this demonstration.

Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a MAGI standard January 1, 2014, will apply to this demonstration.

Mandatory and Optional Medicaid State Plan Groups

| Table 1. Mandatory and Optional Medicaid State Plan Groups | | | |
|---|---|------------------------------|--|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| Budget Population 1 | Aged, blind, and disabled individuals with no third party liability. | Title XIX | ABD no TPL |
| Budget Population 2 | Aged, blind, and disabled individuals with third party liability. | Title XIX | ABD TPL |
| Budget Population 3 | Effective through December 31, 2013, pregnant women with incomes up to 185 percent of the federal poverty level (FPL) and | Title XIX | RIte Care |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| Table 1. Mandatory and Optional Medicaid State Plan Groups | | | |
|--|--|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| Budget Population 3 (continued) | children whose family incomes are up to 250 percent of the FPL who are not otherwise eligible under the approved Medicaid state plan. | Title XIX | Rlte Care |
| | Effective through December 31, 2013, expenditures for parents and caretaker relatives who are not otherwise eligible under the approved Medicaid state plan with incomes that is up to 175 percent of the FPL. | | |
| | Effective January 1, 2014, parents and caretakers up to 133 percent FPL. | | |
| | Effective January 1, 2014, pregnant | | |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| Table 1. Mandatory and Optional Medicaid State Plan Groups | | | |
|---|---|----------------------------------|--|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| | women with incomes up to 185 percent of the FPL and children whose family incomes are up to 250 percent of the FPL who are not otherwise eligible under the approved Medicaid state plan. | | |
| Budget Population 4 | Children who qualify for Medicaid under SSI, children under 21 who are under State Adoption Agreements, Individuals under 21 for whom the state is assuming full financial responsibility, TEFRA section 134 children (Katie Beckett up to age 19). | Title XIX | CSHCN |
| Budget Population 14 | Women screened for breast or cervical cancer under CDC's National Breast | Title XIX | BCCTP |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| Table 1. Mandatory and Optional Medicaid State Plan Groups | | | |
|--|--|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| | and Cervical Cancer Early Detection Program. | | |
| Budget Population 22 | Effective January 1, 2014, expenditures for adults the new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119. | Title XIX | New Adult Group |

Children's Health Insurance Program (CHIP) State Plan Group

| Table 2. CHIP State Plan Group | | | |
|--|---|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| Budget Population 7 | Optional targeted low-income children ages 8 through 18 with incomes up to 250% of the FPL. | Title XXI | CHIP Children |

Demonstration Expansion Groups

| Table 3. Demonstration Expansion Groups | | | |
|---|--|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| Budget Population 5 | Effective through December 31, 2013, women of childbearing age | Title XIX | EFP |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| Table 3. Demonstration Expansion Groups | | | |
|---|--|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| Budget Population 5 (continued) | <p>whose family income is at or below 200 percent of the FPL who lose Medicaid eligibility at 60 days postpartum who do not have access to creditable health insurance. Continued program eligibility for these women will be determined by the twelfth month after their enrollment in the program.</p> <p>Effective January 1, 2014, women of childbearing age whose family income is at or below 250 percent of the FPL who lose Medicaid eligibility at 60 days postpartum. Continued program eligibility for these women will be determined by the twelfth month after their enrollment in the program.</p> <p>Effective through December 31, 2013, expenditures for family planning services for enrollees in the Extended</p> | Title XIX | EFP |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| Table 3. Demonstration Expansion Groups | | | |
|---|--|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| | Family Planning program whose family incomes are between 200 and 250 percent of the FPL for services that are furnished from January 1, 2009, through the date upon which their eligibility for the program is determined using the new net income criteria of 200 percent of the FPL. | | |
| Budget Population 6 | Budget Population 6a. Individuals who, at the time of initial application: (a) are uninsured pregnant women; (b) have no other coverage; (c) have net family incomes between 185 and 250 percent of the FPL; (d) receive benefits only by virtue of the Comprehensive demonstration; (e) | Title XIX | Pregnant Expansion |
| Budget Population 6 (continued) | meet the citizenship and identity requirements specified in the Deficit Reduction Act of 2005; and f) | Title XIX | Pregnant Expansion |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| Table 3. Demonstration Expansion Groups | | | |
|---|---|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| | <p>are covered using title XIX funds if title XXI funds are exhausted.</p> <p>Budget Population 6b [Pregnant Expansion]. Individuals who, at the time of initial application: (a) are pregnant women; (b) have other coverage; (c) have net family incomes between 185 and 250 percent of the FPL; (d) receive benefits only by virtue of the Comprehensive demonstration; and (e) meet the citizenship and identity requirements specified in the Deficit Reduction Act of 2005.</p> | | |
| Budget Population 8 | Parents pursuing behavioral health treatment with children temporarily in State custody with income up to 200 percent of the FPL. | Title XIX | Substitute care |
| Budget Population 9 | CSHCN (as an eligibility factor) who are 21 and under | Title XIX | CSHCN alt |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| Table 3. Demonstration Expansion Groups | | | |
|---|--|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| | who would otherwise be placed in voluntary State custody below 300 percent SSI. | | |
| Budget Population 10 | Effective through December 31, 2013, those at risk for LTC with income at or below 200 percent of the FPL. | Title XIX | Elders 65 and over |
| Budget Population 10 (continued) | Effective January 1, 2014, those at risk for LTC with income at or below 250 percent of the FPL who are in need of home and community-based services (state only group). | Title XIX | Elders 65 and over |
| Budget Population 11 | 217-like Categorically Needy Individuals receiving HCBW-like services & PACE-like participants Highest need group. | Title XIX | 217-like group |
| Budget Population 12 | 217-like Categorically Needy Individuals receiving HCBW-like services and PACE-like | Title XIX | 217-like group |

Rhode Island Comprehensive Demonstration
 Demonstration Approval Period: December 23, 2013 through December 31, 2018
 Amended September 24, 2018

| Table 3. Demonstration Expansion Groups | | | |
|---|---|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| | participants in the High need group | | |
| Budget Population 13 | 217-like Medically Needy receiving HCBW-like services in the community (High and Highest group). Medically Needy PACE-like participants in the community. | Title XIX | 217-like group |
| Budget Population 15 | HCBS waiver like services for adults living with disabilities with incomes at or below 300 percent of the SSI with income and resource lists above the Medicaid limits. | Title XIX | AD Risk for LTC |
| Budget Population 16 | Effective through December 31, 2013, services for uninsured adults with mental illness and or substance abuse problems with incomes below 200 percent of the FPL | Title XIX | Adult Mental Unins |

Rhode Island Comprehensive Demonstration
 Demonstration Approval Period: December 23, 2013 through December 31, 2018
 Amended September 24, 2018

| Table 3. Demonstration Expansion Groups | | | |
|---|---|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| | not eligible for Medicaid. | | |
| Budget Population 17 | Coverage of detection and intervention services for at-risk young children not eligible for Medicaid up to 300 percent of SSI. | Title XIX | Youth Risk Medic |
| Budget Population 18 | Effective through December 31, 2013, services for persons living with HIV with incomes below 200 percent of the FPL who are ineligible for Medicaid. | Title XIX | HIV |
| Budget Population 19 | Effective through December 31, 2013, services for non-working disabled adults ages 19-64 eligible for the General Public cash assistance program, but who do not qualify for disability benefits. | Title XIX | AD Non-working |
| Budget Population 20 | Effective January 1, 2014, adults aged 19-64 who have been diagnosed with Alzheimer's Disease or a related Dementia as determined by a physician, who are at | Title XIX | Alzheimer adults |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| Table 3. Demonstration Expansion Groups | | | |
|---|---|------------------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| Budget Population 20 | risk for LTC admission, who are in need of home and community care services, and whose income is at or below 250 percent of the FPL. | Title XIX | Alzheimer adults |
| Budget Population 21 | Effective January 1, 2014, young adults aged 19-21 aging out of the Katie Beckett eligibility group with incomes below 250 percent of the FPL, who are otherwise ineligible for Medical Assistance, and are in need of services and/or treatment for behavioral health, medical or developmental diagnoses. | Title XIX | Beckett aged out |
| Budget Population 23- Designated State Health Populations | Effective, October 20, 2016 the following DSHP <ol style="list-style-type: none"> 1. Wavemaker 2. Tuberculosis Clinic 3. Rhode Island Child Audiology Center 4. Center for Acute | Title XIX | WM-DSHP TC-DSHP RICAC-DSHP CFAIDE-DSHP |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| Table 3. Demonstration Expansion Groups | | | |
|---|---|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| | <p>Infectious Disease Epidemiology</p> <p>5. Consumer Assistance Program</p> <p>6. Health Workforce Development</p> | | <p>CAP-DSHP</p> <p>HWD-DSHP</p> |
| Budge Population 24 – Recovery Navigation Program (RNP) | Effective February 8, 2018, expenditures to deliver a recovery-oriented environment and care plan dedicated to connecting individuals with a substance use disorder eligible for RNP services as specified in STC 94, with the necessary level of detox, treatment, and recovery services within a less-intensive and less-costly level of care than is furnished in an inpatient hospital setting. | Title XIX | RNP |

| Table 3. Demonstration Expansion Groups | | | |
|---|--|-----------------------|---|
| <i>Demonstration population number</i> | <i>Population description</i> | <i>Funding Stream</i> | <i>CMS-64 Eligibility Group Reporting</i> |
| Peer Recovery Specialists (PRS) | Effective February 8, 2018, expenditures to deliver services using a Peer Recovery Specialist (PRS) who provides an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connections to the community, as well as offer services, as outlined in STC 104, that will focus on the treatment of mental health and/or substance use disorders for those individuals who have trouble stabilizing in the community and/or are in need of supports to maintain their stability in the community. | Title XIX | PRS |

21. AFDC-Related Eligibility Determinations. Effective through December 31, 2013, to reflect a policy of family responsibility, in determining the eligibility of individuals reported in Budget Groups 3, 4, and 7-9, the state considers the income of the applicant based on the entire family unit,

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

including the applicant as well as that of the following family members who reside in the household: (1) individuals for whom the applicant has financial responsibility; (2) individuals who have financial responsibility for the applicant; and (3) any other individual for whom such individual in (2) above has financial responsibility. Note: the income of a step-parent who has financial responsibility is also included when determining eligibility for an applicant child. Effective January 1, 2014, the state will use modified adjusted gross income (MAGI) methodologies for determining income for these populations, consistent with the state plan.

22. Resource Test. Effective through December 31, 2013, the state may elect to impose a resource test so that, notwithstanding the general financial standards described above, the state may elect to limit eligibility for individuals eligible under groups referenced above for parents and caretaker relatives, if they have liquid resources (cash, marketable securities and similar assets) at or above the amount of \$10,000. Pregnant women and children are exempt from this resource test. Effective January 1, 2014, the state will use modified adjusted gross income (MAGI) methodologies for determining income for non-ABD populations and will not impose a resource test.

23. Eligibility Determinations – ABD Related. Eligibility determinations for ABD related populations in the community must follow the income and resource methodologies of the SSI program and the current Medicaid state plan.

24. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized

Individuals. In determining eligibility for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 CFR 435.733.

25. Individuals Receiving Section 1915(c)-Like Services.

- a. Categorically Needy Individuals at the Highest Level of Care. The state will use institutional eligibility and post eligibility rules for an individual who would only be eligible in the institution in the same manner as specified under 42 CFR 435.217, 435.726, and 435.236 and section 1924 of the Act, to the extent that the state operates a program under the demonstration using authority under section 1915(c) of the Act.
- b. Categorically Needy Individuals at the High Level of Care. The state will 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, 435.726, and 435.236 and section 1924 of the Act, to the extent that the state operates a program under the demonstration using authority under section 1915(c) of the Act.
- c. Medically Needy at the High and Highest Level of Care. The state will apply the medically needy income standard plus \$400. Individuals requiring habilitation services will be eligible to receive those services with a High or Highest Level of Care. The state will otherwise use institutional eligibility rules, including the application of spousal impoverishment eligibility rules.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- d. Program for All-Inclusive Care for the Elderly (PACE). For participants at the “highest” level of care, the state will 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 and section 1924 of the Act, if the state had section 1915(c) waiver programs. For participants at the “high” level of care, the state will use institutional eligibility and post eligibility rules for individuals who would not be eligible in the institution in the same manner as specified under 42 CFR 435.217, 435.726 and 435.236 and section 1924 of the Act, if the state had section 1915(c) waiver programs.

26. Maintenance of Current Optional Populations. The State must maintain eligibility of all optional populations that are covered under the Rhode Island Medicaid State Plan as of November 1, 2008, except to the extent that this demonstration expressly permits changes in eligibility methods and standards. Any changes affecting these populations will be considered a Category III Change as specified in paragraph 18 of these STCs. In making any such changes, the State must give priority to extension or continuation of eligibility for optional populations prior to extension or continuation of eligibility for groups not otherwise eligible under the State Plan.

27. Extended Eligibility for Persons Transitioning between Medicaid/CHIP and Qualified Health Plans in the Marketplace. Effective January 1, 2014, the state will extend Medicaid or CHIP eligibility for persons who are transitioning from Medicaid or CHIP to a Qualified Health Plan (QHP) through the Marketplace to the end of the month before QHP coverage may feasibly become effective. If the termination otherwise would have been effective on or before the 15th of a given month, then coverage will be extended to the end of that month. If the termination otherwise would have been effective on or after the 16th of a given month, then coverage will be extended to the end of the following month.

28. Expedited LTC Eligibility. The state may accept self-attestation of the financial eligibility criteria for new LTC applicants for a maximum of ninety (90) days. Eligible individuals would be required to complete the LTC Clinical and Financial Application for LTC services. After Clinical Eligibility criteria has been verified by the state, the individual would provide a self-attestation of the LTC financial eligibility criteria to receive a limited benefit package of community based LTSS for up to 90 days pending the determination of the full LTC financial application. The limited benefit package includes a maximum of twenty (20) hours weekly of personal care/homemaker services and/or a maximum of three (3) days weekly of Adult Day Care Services and/or limited skilled nursing services based upon assessment. Upon determination of the approval of the full LTC financial application, the individual will receive the full LTC benefit package. The limited community based LTSS services is available for up to ninety (90) days or until the eligibility for LTC decision is rendered, whichever comes first.

29. Referral for More Comprehensive Coverage. Effective January 1, 2014, in order to ensure that vulnerable populations who are not currently covered by a comprehensive health insurance plan, but receive only services through expenditure authority as described in Budget Populations 16, 18, and 19, have the opportunity to access more comprehensive care, the state must ensure that the providers that serve these individuals refer and educate them on how to apply for more comprehensive

insurance. All individuals included in the demonstration, including the new adult group, are eligible to receive services in Attachment A.

30. Efficient Transition to Coverage in the New Adult Group. Individuals enrolled in Budget Populations 16, 18, and 19 prior to December 31, 2013, who have incomes up to and including 133 percent of the FPL will be eligible in the new adult group under the state plan. The state must engage in extensive outreach efforts to assure that individuals with incomes up to 133 percent of the FPL are enrolled into comprehensive Medicaid coverage. This STC will sunset on October 18, 2016.

- a. The state must attempt to contact every individual expected to lose limited benefit coverage through the demonstration and move to full Medicaid coverage;
- b. The state must assure that there is no duplication of federal funding when individuals in Budget Populations 16, 18, and 19 are enrolled to the New Adult Group.
- c. No later than January 31, 2014, the state must collect data to determine whether individuals have lost demonstration coverage but have not enrolled in full Medicaid coverage. The state must share these data with CMS in writing on a monthly basis.

31. Efficient Transition to Marketplace Coverage. Effective January 1, 2014, the state reduce eligibility for parents caretaker relatives from 175 percent to 133 percent of the FPL. The state must engage in extensive outreach efforts to assure that individuals with incomes above 133 through 175 percent are seamlessly enrolled into Marketplace coverage. This may include, but is not limited to, the following actions:

- a. The state must attempt to contact every individual expected to lose Medicaid coverage and move to Marketplace coverage;
- b. The state must conduct community events, which will include information sessions dedicated to sharing information to assist individuals moving from Medicaid coverage to Marketplace coverage;
- c. The state must conduct significant outreach and communication strategies to Marketplace Subsidy Program enrollees to ensure that they are able to remain in a QHP after January 31, 2014. when they will no longer be eligible for a premium holiday, as outlined in STC 89
- d. No later than January 31, 2014, the state must collect data to determine whether individuals have lost Medicaid coverage but have not enrolled in Marketplace coverage. The state must share these data with CMS on a monthly basis through March 31, 2014.

VI. BENEFITS

32. General. Benefits provided through this demonstration program are as follows:

Rhode Island Comprehensive Demonstration
Demonstration Approval Period: December 23, 2013 through December 31, 2018
Amended September 24, 2018

- a. RIt 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, as outlined in the State Plan. Benefits that are available to RIt Care enrollees under this demonstration include all benefits listed in Attachment A and under the Medicaid State Plan. To the extent that the state complies with the provisions of section IV to make changes in the benefit package, the state has the flexibility to provide customized benefit packages to beneficiaries based on medical need. All changes in benefits (whether reductions or additions) provided through the approved alternative benefit plan SPA, for the new adult group described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act must be submitted as an amendment to the state plan.
- b. Alternative Benefit Plan. Effective January 1, 2014, the New Adult Group will receive benefits provided through the state's approved alternative benefit plan (ABP) state plan amendment (SPA), which are effective, as of the effective date in the approved ABP SPA. Individuals in the New Adult Group may receive, as part of their ABP under this demonstration, Expenditure Authority services such as Managed Care Demonstration Only Benefits specified in Attachment A of the STCs.
- c. Extended Family Planning Program. Family planning services and referrals to primary care services are provided to eligible recipients at or below 250 percent of the FPL who lose Medicaid eligibility at the conclusion of their 60-day postpartum period. See Section X for more detailed requirements.
- d. Long-Term Care and HCBS. Long term care services are provided when medically necessary to certain individuals eligible under the Medicaid state plan. As indicated above, the New Adult Group will receive benefits provided through the state's approved ABP SPA. Benefit packages include long-term care and home and community-based services based on medical necessity and an individual's person-centered plan of care. The state agrees that the entity responsible for assisting the individual with development of the person-centered service plan may not be an LTSS service provider, unless that service provider is the only qualified and willing entity available to conduct the service planning. If a service provider is the only willing and qualified entity to conduct service planning, the state must establish firewalls between the service provision and planning functions to ensure conflict of interest protections. The state assures that conflict of interest protections will be in compliance with the characteristics set forth in 42 CFR 441.301(c)(1)(v)(vi). Benefit packages for all individuals who meet the highest, high, or preventive level of care criteria will include access to core and preventive HCBS, as described in paragraph 33, subject to any waiting list as described in paragraph 34. The core and preventive service HCBS definitions are included in Attachment B of this document. The state will assure compliance with the characteristics of HCBS settings as described in 1915(c) and 1915(i) regulations in accordance with implementation/effective dates in accordance with 42 CFR 441.301(c)(4). More detailed requirements are provided in this section.

- e. Limited Benefit Packages. Individuals in Budget Populations 10, 16, 18, 19, and 20 are eligible for limited benefits under the demonstration. Benefit packages may include, but are not limited to, limited pharmacy, physical health, or mental health services.

33. Long-Term Care and HCBS. Individuals eligible as aged, blind or disabled (ABD) under the Medicaid state plan will receive benefits for institutional and home and community-based long term care services including an option for self-direction. 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 can 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. Long term care services under this demonstration will include coverage of HCBS-like services that are equivalent to the services previously furnished under section 1915(c) HCBS waivers, including waiver numbers 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, managed care delivery systems of Rhody Health Options or Connect Care Choice Community Partners 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.

34. 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

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

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.

- 35. 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 he or she 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.
- 36. Program for All-inclusive Care for the Elderly (PACE).** PACE is subsumed under this section 1115 demonstration program and will remain an option for qualifying demonstration eligibles, that is, those that meet the High or Highest level of care determinations. The state assures that demonstration eligibles who may be eligible for the PACE program are furnished sufficient information about the PACE program in order to make an informed decision about whether to elect this option for receipt of services. The state will comply with all Federal requirements governing its current PACE program, and any future expansion or new PACE program, in accordance with section 1934 of the Social Security Act and regulations at Part 460 of Title 42 of the Code of Federal Regulations.
- 37. Long-Term Care Insurance Partnership.** The state must implement a Long-Term Care Insurance Partnership Program as described in the Rhode Island state plan. Under the Long-Term Care Insurance Partnership Program, an individual who is a beneficiary under a qualified long-term care insurance policy is given a resource disregard equal to the amount of insurance benefit payments made to or on behalf of the individual. The state does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

COST SHARING

38. Any premiums or copay requirements are specified in the Medicaid state plan. Demonstration populations may be charged premiums that do not exceed the premiums specified below.

| | Premium Limits for Budget Populations 3, 6, and 8 | | | | |
|--|---|----------------------------------|--|----------------|--------------------------|
| Family Income Level | children under 1* | children 1 to 19th birthday* | adults | pregnant women | extended family planning |
| At least 150 percent but not more than 185 percent FPL | None | Up to 5 percent of family income | Up to 5 percent of family income | None | None |
| Over 185 percent but not more than 200 percent FPL | None | Up to 5 percent of family income | Up to 5 percent of family income | None | None |
| Over 200 percent but not more than 250 percent FPL | None | Up to 5 percent of family income | Up to 5 percent of family income | None | None |
| *no cost sharing or premiums for children in foster care or adoption subsidy | | | No cost-sharing for: pregnant women, children under age one (1), children in foster care or adoption subsidy, Chafee children, Alaskan Native/American Indian children and adults. | | |

- Cost-sharing for BBA working disabled adults defined in section 1902(a)(10)(A)(ii)(XIII) will follow the Medicaid state plan
 - All unearned income over the Medically Needy Income Limit (MNIL) will be owed as a monthly premium;
- Cost-sharing for Budget Population 10 is to be treated like post-eligibility treatment of income or spend-down requirements.
- In order to prevent families from being burdened by two sets of premium payments, for households with incomes between 150 percent FPL and 250 percent FPL in which children

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

are Medicaid eligible and enrolled in RIte Care, and parent/caretaker relatives are enrolled in commercial coverage, will no longer be required to pay the Medicaid premium, only the premium associated with the commercial coverage.

- DELIVERY SYSTEM

39. Assessment and Coordination Organization Process. Access to institutional and community-based supports and services will be through the Assessment and Coordination Organization (ACO) process. 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 process will involve the beneficiary and involved family members, and treating practitioners and providers to ensure comprehensive assessments and care planning. The ACO is described more fully in Attachment C.

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

- a. Managed Long Term Services and Supports. Beneficiaries will have access to long term care services and supports through their enrollment in Rhody Health Options or Connect Care Choice Community Partners
- b. 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.
- c. Self-direction. Beneficiaries (or, as they authorize, 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 section 1915(c) Cash and Counseling Waiver (*RI Personal Choice*), section 1915(c) Developmental Disabilities Waiver, and Personal Assistance Service and Supports program. Self-direction is fully described in the Self-direction Operations Section.

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

- a. Managed Care Organizations: RIté Care, Rhody Health Partners, Rhody Health Options or Connect Care Choice Community Partners
- b. Primary Care Case Management Program: Connect Care Choice
- c. Pre-paid Dental Ambulatory Health Plans: RIté Smiles
- d. PACE: PACE Organization of Rhode Island
- e. Premium Assistance: Rite Share

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

f. Fee-for-service

- 42. Contracts.** On those occasions that contracts with public agencies are not competitively bid, those payments under contracts with public agencies shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).
- 43. Freedom of Choice.** An enrollee's freedom of choice of providers through whom the enrollee may seek services shall be limited. This applies to all populations enrolled in the Comprehensive demonstration. No waiver of freedom of choice is authorized for family planning providers.
- 44. Selective Contracting.** The state may pursue selective contracting in order to restrict the provider from (or through) whom an individual can obtain services. Emergency services and family planning services will not be covered by this provision. Providers with whom the state contracts will meet, accept, and comply with the reimbursement, quality, and utilization standards under the state plan, which standards shall otherwise be consistent with section 1923 of the Act. These standards are consistent with access, quality, and efficient and economic provision of covered care and services. Restrictions on providers will not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services.

If the state pursues selective contracting for nursing facilities, the state must submit, for CMS review and approval, a description of the process for selecting providers of nursing facility services and allocating nursing facility beds. The state must demonstrate that the process used to select providers of nursing facility services and to allocate Medicaid reimbursed nursing facility beds is consistent with access, quality, and efficient and economic provision of care and services for all participants needing nursing facility services including special regard to access to services for individuals with complex long-term care needs.

- 45. Process for the Review and Approval of Contracts.** The following process applies to contracts between the state and managed care organizations, pre-paid ambulatory health plans; primary care case management providers, and contracts pursuant to the selective contracting process.

All contracts listed above and modifications of existing contracts must be approved by CMS prior to the effective date of the contract or modification of an existing contract. The state will submit to CMS copies of the contracts or modifications and documentation supporting compliance with state and Federal statutes, regulations, special terms and conditions, and waiver and expenditure authority 45 days prior to implementation

VII. Health System Transformation Project

The Health System Transformation Project will provide that Medicaid managed care entities must enter into arrangements with state-certified Accountable Entities (AE) as a condition of receiving a

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

managed care contract. Such contracts, including the AE provision, will meet the requirements of 42 CFR 438.

46. Hospital and Nursing Facility Incentive Program- In response to the Medicaid Managed Care Rule and Regulation (42 CFR 438.6) providing authority to make incentive payments to provider, Rhode Island's Executive Office of Health and Human Services (EOHHS) developed and is implementing the Hospital and Nursing Home Incentive program, inclusive of data collection, performance measurement and scoring, dollar allocation for payment to providers, and funds distribution. These one-time payments for the Hospital and Nursing Facility Incentive Program, which are not to exceed \$20.5 million in DY 8, will be made on or before December 31, 2017.

- a. EOHHS will develop and implement the program, inclusive of data collection, performance measure scoring, and dollar allocation as defined further below under Methodology.
- b. EOHHS will distribute payments to providers via the MCOs.
- c. Providers will be awarded incentive payments based on a set of measures that will demonstrate institutional providers' efforts towards value-based contracting arrangements, cost effectiveness, and alignment with key clinical interventions. EOHHS will distribute payments to providers via the MCOs who will distribute the payments to their contracted providers.
- d. The MCOs will make a payment to the applicable hospital or nursing facility based on demonstrated achievement of pre-determined performance benchmarks for established measures; if the hospital or nursing home facility does not achieve the benchmark, no payment will be made. The measures are listed in Attachment J.
- e. Each Health Plan will receive payment that corresponds to a specific provider performance report that details each specific hospital and nursing facility, the performance measure, baseline for each measure, identified benchmark, performance score, and dollars allocated for each measure.
- f. Each Health Plan will use this report to make the incentive payment to each applicable hospital and nursing facility on a scheduled basis as determined by EOHHS. The total amount to be paid for each provider will be equally distributed among each Health Plan for hospitals.
- g. Payments for each participating Hospital and Nursing Home Facility are contingent on the entity fully meeting project metrics defined in the approved Hospital and Nursing Home facility specific measures listed in Attachment J,

47. Accountable Entities-The following process applies to contracts between the state and managed care organizations (MCO) that require the contractor to subcontract with Accountable Entities

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

(AE). AEs are integrated provider organizations that are accountable for the total cost of care and healthcare quality and outcomes of an attributed population.

- a. There will be two “types” of qualified AEs depending on the capacity and focus of the participating entities:
 - 1) Type 1 Accountable Entity: Total Population, All Services. Authority to contract for an attributed population, for all Medicaid services. A Type 1 AE must be accountable for the total cost of care of an attributed Medicaid population (a “TCOC methodology”).
 - 2) Type 2 Accountable Entity (Interim)-: Specialized Population, All Services. Authority to contract for a specialized population, for all Medicaid services. A Type 2 AE must be responsible for the total cost of care for a specific, defined population (e.g., persons with Serious or Persistent Mental Illness or Serious Mental Illness) and all Medicaid covered services. For specialized AEs where TCOC methodologies may not be appropriate, other APM models will be implemented.
- b. Rhode Island will require in its managed care contracts, that managed care entities will subcontract with state-certified AEs to provide accountability for the costs of care furnished under the contract.
- c. The state must develop AE Certification Standards that the state will use to certify the potential AEs within the state. The final certification standards will be submitted to CMS to review, by June 1, 2017 as Attachment K; CMS has 60 days to review and submit suggestions to the state. The state will notify the MCOs of the approved certified AEs. After an organization is certified as an AE and it elects to make a material modification, a request for a substantive change (examples include a benefit enhancement, new provider network arrangements, change in AE governance), the state must review and approve such modification in the AE’s operations, prior to the implementation of the AE.
- d. The certification standards will provide that AEs are integrated provider organizations that are accountable for the total cost of care and healthcare quality and outcomes of an attributed population. For specialized AEs where TCOC methodologies may not be appropriate, other APM models will be implemented. The MCOs, pursuant to contract requirements with the state, will subcontract with AEs in compliance with the In-Plan Medicaid managed care benefit package.
- e. Prior to the MCOs contracting with AEs, EOHHS will develop Alternative Payment Methodology (APM) guidelines, which MCOs must follow in contracting with certified AEs. This methodology shall include quality benchmarks and outline the services that will be covered under the Type 1 and Type 2 Accountable Entities. The state must review and

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

approve each MCO's APM methodologies and associated quality gates prior to implementation. The APM methodology document will be submitted to CMS for review and approval by 10/1/2017 as Attachment L and may be updated annually. The MCO must utilize the APM methodology to calculate the shared savings if applicable for each AE. MCO members will be attributed to an AE pursuant to the EOHHS Attribution Guidance for the AE Program- Attachment M, which may be updated annually.

- f. Certified AEs who contract with MCOs in accordance with state specified APM guidance will be eligible to participate in an AE Incentive Program. This APM guidance will include AE Incentive Program guidelines which MCOs must follow in contracting with certified AEs. The state must review and approve each MCO's AE Incentive Program as compliant with the standards.
- g. The MCO members' freedom to choose or change their providers shall not be affected by attribution to an AE. The state remains responsible for oversight of the MCOs and will augment oversight activities to ensure that the MCOs are assessing the performance of their AE subcontractors. The MCOs remain responsible for overseeing the services that are delegated to the subcontracted AEs so that the MCO remains compliant with the terms of both the contract it has with the state and as required under 42 CFR §438.230(b)(1).

48. Accountable Entity Roadmap. The State must develop an Accountable Entity Roadmap for the Health System Transformation Project to be submitted to CMS for approval by June 1, 2017. CMS has 60 days to review and approve the roadmap document. The Accountable Entity Roadmap will contain requirements regarding the AE's accountability for the total costs of care and healthcare quality and outcomes for an attributed population. The Roadmap is considered a conceptualized living document that will be updated annually to ensure that best practices and lessons are learned throughout implementation that can be leveraged and incorporated into the State's overall vision of delivery system reform. This Roadmap will demonstrate the State's ambition and outline what the State and its stakeholders consider the payment reforms required for a high quality and a financially sustainable Medicaid delivery system.

Once approved by CMS, this document will be incorporated as Attachment N of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved waivers, expenditure authorities and STCs. (Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols.) The State may not claim FFP for the AE Incentive Program until after CMS has approved the Roadmap.

Payments for each participating AE are contingent on the AE fully meeting project metrics defined in the approved APM guidance document – Attachment L. In order to receive incentive

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

funding relating to any metric, the AE must submit all required reporting, as outlined in the Accountable Entity Roadmap. In addition, the Roadmap must include the following elements:

- a. Specify that the APM guidance document will define a menu of metrics and measures that will be used by the MCOs to assess the performance of the AEs through the activities of the AE subcontractors.
- b. Include guidelines requiring AEs to develop individual AE Health System Transformation Project Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance.
- c. Report to CMS any issues within the AEs that are impacting the AE's ability to meet the measures/metrics, or any negative impacts to enrollee access, quality of care or beneficiary rights. The state, working with the MCOs, shall monitor statewide AE performance, trends, and emerging issues within and among AEs on a monthly basis, and provide reports to CMS on a quarterly basis.
- d. Provide minimum standards for the process by which EOHHS seek public input in the development of the AE Certification Standards;
- e. Specify a State review process and criteria to evaluate each AE's individual Health System Transformation Project Plan and develop its recommendation for approval or disapproval;
- f. Describe, and specify the role and function, of a standardized, AE-specific application to be submitted to the State on an annual basis for participation in the AE Incentive Program, as well as any data books or reports that AEs may be required to submit to report baseline information or substantiate progress;
- ~~g.~~ Specify that AEs must submit semi-annual reports to the MCO using a standardized reporting form to document its progress in achieving quality and cost objectives, that would entitle the AE to qualify to receive AE Incentive Program Payments;
- h. Specify that each MCO must contract with Certified AEs in accordance with state defined APM guidance and state defined AE Incentive Program guidance. The APM guidance will include a Total Cost of Care (TCOC) methodology and quality benchmarks. For specialized AEs (Type 2 AE) where TCOC methodologies may not be appropriate, other APM models will be specified. Describe the process for the state to review and approve each MCO's APM methodologies and associated quality gates to ensure

compliance with the standards and for CMS review of the APM guidance as stated in STC 47(e).

- i. Specify the role and function of the AE Incentive Program guidance to specify the methodology MCOs must use to determine the total annual amount of AE Incentive Program payments each participating AE may be eligible to receive during implementation. Such determinations described within the APM guidance document shall be associated with the specific activities and metrics selected of each AE, such that the amount of incentive payment is commensurate with the value and level of effort required; these elements are included in the AE incentive plans referenced in STC 47(f). Each year, the state will submit an updated APM guidance document, including APM Program guidance and the AE Incentive Program Guidance.
- j. Specify a review process and timeline to evaluate AE progress on its AE Incentive Program metrics in which the MCO must certify that an AE has met its approved metrics as a condition for the release of associated AE Incentive Program funds to the AE;
- k. Specify that an AE's failure to fully meet a performance metric under its AE Incentive Program within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
- l. Describe a process by which an AE that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated AE Incentive Program Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric and, where appropriate, in combination with timely performance on a subsequent related metric defined as demonstrating continued progress on an existing metric. For example, if the failed metric was related to developing a defined affiliation with a Community Business Organization or CBO, and that deliverable was late, the AE might then also be required to show it has adapted its governance model by incorporating into its bylaws and board protocols the requirement to develop a defined relationship with a CBO.
- m. Include a process that allows for potential AE Health System Transformation Project Plan modification (including possible reclamation, or redistribution of incentive payments pending State approval)
- n. Include a process to identify circumstances under which a plan modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved; and

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- o. Include a State process of developing an evaluation of Health System Transformation Project as a component of the draft evaluation design as required by STC 132.

49. Under the current managed care regulatory requirements for state direction of MCO payments (42 CFR 438.6(c)), Rhode Island will need to ensure that the measurement period of any of the performance based metrics and incentive payments within the Health Systems Transformation Project are developed and measured over the same term of the contract as the corresponding rate certification. With the exception of the Hospital and Nursing Home Incentive Program for DY 8, the calculation of the performance-based incentive payments will be based on the current year's performance. The state will also need to meet the prior approval requirements for directed expenditures (e.g., incentive payments) in 438.6(c)(2) for contracts with rating periods starting on or after July 1, 2017. CMS will not approve rate certifications or contracts that include directed expenditures that have not been approved prior to the start of the rating period.

VIII. SELF-DIRECTION

- 50. Required Elements of Self-Direction.** The state must meet the following requirements to operate its self-direction program for core and preventive services including through a High-Fidelity Wraparound process to assess the needs of the whole family, for children in residential treatment who are transitioning back to a home-based setting.
- 51. Voluntary Program.** The program is voluntary for demonstration eligibles who are eligible for and receiving home and community based long-term care services and supports.
- 52. Paid Providers of Services.** Except for legally liable relatives, such as spouses and parents, any individual capable of providing the assigned tasks and freely chosen by a participant to be a paid provider of self-directed services and supports may be hired by the participant. Participants retain the right to: 1) train their workers in the specific areas of services and supports needed; 2) have those services and supports furnished in a manner that comports with the participants' personal, cultural, and/or religious preferences; and 3) access other training provided by or through the state for their workers so that their workers can meet any additional qualifications required or desired by the participants.
- 53. Information Furnished to Participants.** The following information must be provided to participants: principles and benefits of participant direction; participants' rights, roles and responsibilities; self-direction election form; description of other feasible alternatives; fiscal/employer agent contact information; counseling/service advising agency contact information; grievance and appeal process and forms; roles and responsibilities of the fiscal/employer agent and the counseling/advising agency; and participant-directed planning. Trained advisers from the service advisement agency will provide the information to participants.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- 54. Assessment.** An assessment of an individual's needs, strengths, and preferences for services, as well as any risks that may pose a threat of harm to the individual, will be completed. The assessment includes information about the individual's health condition, personal goals and preferences, functional limitations, age, school, employment, household and other factors that are relevant to the authorization and provision of services. The assessment information supports the development of the person-centered service plan and individual budget.
- 55. Person-Centered Planning.** The state must utilize a person-centered and directed planning process, intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the participant. An Individual Service and Spending Plan (ISSP) is developed with the assistance of the service advisor team and those individuals the participant chooses to include. The ISSP includes the services and supports that the participant needs to live independently in the community. A back-up plan must be developed and incorporated into the ISSP to assure that the needed assistance will be provided in the event that the regular services and supports identified in the ISSP are temporarily unavailable. The back-up plan may include other individual assistants or agency services. The state shall have a process that permits participants to request a change to the person-centered plan, if the participant's health circumstances necessitate a change, but in any event, the ISSP will be reviewed and updated at least annually. Entities or individuals that have responsibility for service plan development may not provide other direct demonstration services to the participant.
- 56. Employer Authority.** Participants have the opportunity to exercise choice and control (i.e., hire, fire, supervise, manage) over individuals who furnish their long term care demonstration services authorized in the person-centered service plan. In this demonstration, the participant functions as the employer of record of workers who furnish direct services and supports to the participant.
- 57. Budget Authority.** Participants also have the opportunity to exercise choice and control over a specified amount of funds in a participant-directed budget. Under the budget authority, the participant has decision-making authority and management responsibility for the participant-directed budget from which the participant authorizes the purchase of long term care demonstration services and supports that are authorized in the person-centered service plan.
- 58. Individual Budget.** An individual budget is the amount of funds available to the participant to self-direct. It is developed using a person-centered planning process; based on actual service utilization and cost data and derived from reliable sources; developed using a consistent methodology to calculate the resources available to each participant that is open to public inspection; and reviewed according to a specified method and frequency. A change in the budget must also result in a change to the person-centered plan.
- 59. Information and Assistance in Support of Participant Direction.** The state shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage his or her self-directed services and budgets. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall also have access to the support system throughout the time that they are self-directing their care. Support activities include, but are not limited to, advisement agency services and financial management services.

- 60. Counseling/Advisement Agencies.** The state shall provide each participant with a Service Advisor from a counseling/advisement agency that conducts participant screening, assessment and reassessment; participant orientation, training, preparation, and support of all participant functions; participant assistance in spending plan development and monitoring; and ongoing monitoring of participant satisfaction, health and safety. Counseling/advisement agencies shall meet state established certification standards to provide supports to participants.
- 61. Financial Management Services.** The state shall provide financial management services (FMS) that: provide payroll services for program participants and/or designated representatives; are responsible for all taxes, fees, and insurances required for the program participant to act as an employer of record; manage all non-labor related payments for goods and services authorized in the participant's approved spending plan; assure that all payments made under the demonstration comply with the participant's approved spending plan; and conduct criminal background and abuse registry screens of all participant employees at the State's expense. FMS entities shall meet IRS requirements of being a fiscal/employer agent and state established certification standards to provide supports to participants. FMS shall be reimbursed as an administrative activity at the 50 percent administrative rate.
- 62. Services to be Self-Directed.** Participants who elect the self-direction opportunity will have the option to self-direct all or some of the long-term care core and preventive services and supports under the demonstration. The services, goods, and supports that participants will self-direct are limited to the core and preventive services, listed in Attachment B. Services, goods, and supports that are not subject to employer and budget authority, i.e., participants do not have hiring authority and do not become the employer of record over these services, goods or items, will still be included in the calculations of participants' budgets. Participants' budget plans will reflect the plan for purchasing these needed services, goods and supports.
- 63. Individual Directed Goods and Services.** Individual directed goods and services may be purchased from accumulated funds ("savings") as approved in the individual budget plan. Goods and services must relate to a need or goal identified in the person-centered service plan. Accumulated funds or savings may be carried over from month to month, and year to year, only if designated for a specific good or service. If the goods or services are not purchased at the time indicated in the budget plan, the state will recoup any unspent and un-earmarked funds at designated intervals and according to procedures established by the state. Goods and services that can be individually directed are defined in Attachment B Core and Preventive Services.
- 64. Participant Direction by Representative.** The state provides for the direction of services by a representative. The representative may be a legal representative of the participant or a non-legal representative freely chosen by an adult participant. The representative shall not be paid and must pass a screen indicating ability to perform the functions in the best interest of the participant and must pass a criminal background check. A participant who demonstrates the inability to self-direct his or her services and supports whether due to misuse of funds, consistent non-adherence to program rules or an ongoing health and safety risk, will be required to select a representative to assist him or her with the responsibilities of self-direction. If a participant refuses to select a representative, or if a participant loses a representative (if already required for participation) and

cannot locate a replacement, he or she will be required to transfer to a non-self-directed traditional service delivery system. Service advisors will assist the participant in the transition to the traditionally delivered service system to ensure continuity of care.

- 65. Independent Advocacy.** Each participant shall have access to an independent advocate or advocacy system in the state. This function is performed by individuals or entities that do not provide direct services, perform assessments, or have monitoring, oversight or fiscal responsibilities for the demonstration.
- 66. Service Plan Monitoring.** The Service Advisor shall, at a minimum, make quarterly in-person visits to the participant and monthly telephone contact in the first year, then semi-annual in-person and quarterly phone contact thereafter or more when requested or indicated by concern. Additionally, the RN and Mobility Specialist assess for needs at least annually. The entire Service Advisor Team is available to the participant upon request and/or Advisor identification of a potential health/safety concern.
- 67. Expenditure Safeguards.** The FMS reports monthly to the participant and the Service Advisor, and quarterly to the state, on the budget disbursements and balances. If more than 20 percent underutilization of authorized services is discovered, the Service advisor will work with the participant in assessing the reason and crafting a solution, such as a new worker or a reassessment of needs.
- 68. Disenrollment.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. A participant may also be involuntarily disenrolled from the self-directed option for cause, such as a continuous demonstrated inability to self-direct his or her services and supports whether due to misuse of funds, consistent non-adherence to program rules or an ongoing health and safety risk. A participant who has demonstrated an inability to self-direct his or her services and supports will be required to select a representative to assist the participant with the responsibilities of self-direction. If a participant voluntarily or involuntarily disenrolls from the self-directed service delivery option, the state must have safeguards in place to ensure continuity of services.
- 69. Fair Hearing.** Participants may request a fair hearing when a reduction in services occurs or when a requested adjustment to the budget is denied or the amount of the budget is reduced.
- 70. Cash Option.** At such time as the state elects, a participant may elect to receive the amount of the funds in his or her individual budget in a prospective cash disbursement. Prior to the election of the cash option, the state will notify CMS of this election according to the Process for Category II changes. Prior to implementation of the cash option, the state will secure a waiver of the income and asset requirements from the Social Security Administration.
- 71. Additional Populations and Services.** At such time as the state elects to add additional populations or services to the self-direction option, the state will notify CMS of this election according to the Process for Category II changes. If, however, the State's proposal to add populations or services

exceeds or changes the expenditure authorities of section 1915(c), 1915(i) or 1915(j), the state will follow the Process for Category III changes.

- 72. Personal Needs Allowance.** Effective January 1, 2014, the state will increase the monthly personal needs allowance by \$400 for certain persons categorically eligible or eligible as medically needy for Medicaid-funded long-term services and supports. These individuals will have resided in a nursing facility for 90 consecutive days, excluding those days that may have been used for the sole intent and purpose of short term rehabilitation; are transitioning from a nursing facility to a community residence, and are assessed to be unable to afford to remain in the community unless the personal needs allowance is increased. This would not apply to individuals who are residing in a nursing facility and whose income is being used to maintain a current community residence.

IX. EXTENDED FAMILY PLANNING PROGRAM

- 73. Eligibility Requirements.** Family planning and family planning-related services and supplies are provided to individuals that are redetermined eligible for the program on an annual basis. The state must enroll only women, meeting the eligibility criteria below into the demonstration who have a family income at or below 200 percent of the FPL (through December 31, 2013) and at or below 250 percent of the FPL (beginning January 1, 2014) and who are not otherwise enrolled in Medicaid or Children's Health Insurance Plan (CHIP). Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum and who have a family income at or below 200 percent of the FPL (through December 31, 2013) and at or below 250 percent of the FPL (beginning January 1, 2014) at the time of annual redetermination are auto enrolled in the Extended Family Planning group.
- 74. Primary Care Referral.** Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services.
- 75. Eligibility Redeterminations.** The state must ensure that redeterminations of eligibility for this component of the demonstration are conducted, at a minimum, once every 12 months. At the State's option, redeterminations may be administrative in nature.
- 76. Disenrollment from the Extended Family Planning Program.** If a woman becomes pregnant while enrolled in the Extended Family Planning Program, she may be determined eligible for Medicaid under the State plan. The State must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid State plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Extended Family Planning Program.

77. Extended Family Planning Program Benefits. Benefits for the family planning expansion group are limited to family planning and family planning-related services. Family planning services and supplies described in section 1905(a)(4)(C) of the Act and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:

- a. Approved methods of contraception;
- b. Sexually transmitted infection (STI) testing, Pap smears and pelvic exams;

Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

- c. Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements); and
- d. Contraceptive management, patient education, and counseling.

78. Family Planning-Related Benefits. Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the State's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include:

- a. Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
- b. Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
- c. Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered.
- d. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- e. Treatment of major complications (including anesthesia) arising from a family planning procedure such as:
 - i. Treatment of a perforated uterus due to an intrauterine device insertion;
 - ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
 - iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

79. Services. Services provided through the Extended Family Planning program are paid either through a capitated managed care delivery system or fee for service (FFS).

X. RITE SMILES

80. Rite Smiles. The Rite Smiles Program is a managed dental benefit program that was previously operated under a waiver pursuant to section 1915(b) of the Act. Beneficiaries eligible for this program are Medicaid-eligible children born on or after May 1, 2000. The managed care delivery system is continuing under this demonstration. Under this demonstration, the state will continue to administer the program through a pre-paid ambulatory health plan contract. The benefit design will remain the same under this demonstration.

XI. DESIGNATED STATE HEALTH PROGRAMS (DSHP)

DESIGNATED STATE HEALTH PROGRAMS

81. Designated State Health Programs (DSHP). To solely support the goals of the Health System Transformation Project, the state may claim FFP for the following state programs subject to the annual limits and restrictions described below through December 31, 2018, unless otherwise specified. Designated State Health Programs enables the state to improve health outcomes and increase the efficiency and quality of care by providing payments for services/activities (e.g., TB Program, etc.). Expenditures are claimed in accordance with CMS-approved claiming and documentation protocols to be specified in the Claiming Protocols; Attachment P, Attachment Q, and Attachment S. In order to ensure achievement of the demonstration's goals, the total annual expenditure authority is subject to the requirements of STC #82. CMS has approved expenditure authority for Designated State Health Programs (DSHP) with the agreement that this one-time (i.e., non-renewable) investment of DSHP funding would be phased down over the demonstration period.

82. Annual DSHP Annual Limits – Expenditure authority for DSHP is limited to \$79,980,610 million FFP, beginning on the date of approval through December 31, 2018, allocated by year as follows:

Table 4: Aggregate DSHP Annual Limits

| Demonstration Year | Time Period | Annual Limit on FFP |
|--------------------|-------------------|---------------------|
| DY 8 | 10/14/16-12/31/16 | \$20,500,000 |
| DY 9 | 1/1/17-12/31/17 | \$31,071,000 |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| | | |
|-------|---------------------|--------------|
| DY 10 | 01/01/2018-12/31/18 | \$28,409,610 |
|-------|---------------------|--------------|

Allowable DSHP claims, for each program described below are limited to the allowable DSHP costs incurred for the months of the time period and Demonstration Year (DY) per the STCs. For this demonstration, Rhode Island DSHP claims can occur beginning on the date of approval (DY 8) through December 31, 2018 (DY10).

83. Prohibited DSHP Expenditures. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants (for example, grants from the Health Resources and Services Administration, or the Centers for Disease Control, or that are included as part of the maintenance of effort or non-federal share requirements of any federal grant. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to non-qualified aliens. To implement this limitation, 9 percent of total provider expenditures or claims through the Tuberculosis Clinic, Center for Acute Infectious Disease and Epidemiology, and Consumer Assistance Programs DSHPs identified below will be treated as expended for non-emergency care to non-qualified aliens.

84. Restrictions on DSHP Programs. Approved Designated State Health Programs for which FFP can be claimed for 3 years are outlined below subject to the following funding limits by the categories listed below. This funding will solely support vital state health programs and workforce development programs to enable the state to devote resources to developing and supporting the transition to Accountable Entities, which will result in a temporary increase in state expenditures on the Medicaid program over the term of these STCs. Prior to claiming funding for any of the new DSHPs, the state will submit a DSHP claiming protocol that CMS must approve prior to receiving FFP. The claiming protocol will include expenditures claimed in accordance with CMS-approved claiming and documentation protocols to be specified in Attachment P, Attachment Q, and Attachment S. The state is not eligible to receive FFP for any of the DSHPs until the corresponding protocols are approved. Upon CMS approval of each claiming protocol, the state is eligible to receive FFP for the corresponding approved DSHP program expenditures beginning with the date of this approval. The state may claim federal match for any of the DSHPs listed below in accordance with the Claiming Protocol in Attachment P, Attachment Q and Attachment S, as long as the aggregate amount over the 3 year period does not exceed the aggregate limits as specified in STC 82:

- Wavemaker Fellowship
- Tuberculosis Clinic
- Rhode Island Child Audiology Center
- Center for Acute Infectious Disease Epidemiology*
- Consumer Assistance Programs
- Health Workforce Development

- a. **Wavemaker.** The state may claim FFP for expenditures under the Wavemaker Program for DYs 8-10. The Wavemaker Fellowship, a state-funded loan repayment program. The Wavemaker Fellowship will allow for graduates working in the healthcare settings to serve and make an impact on the health care of Medicaid beneficiaries. The state may claim FFP only for Fellowship costs that are conditional on loan repayment beneficiaries serving a high proportion of Medicaid patients. To ensure that DSHP funds promote the development of the Wavemaker Program to benefit the Medicaid population and improve access, the State shall commit to implementing a Methodology Protocol for the Wavemaker Program that will be Attachment Q.
- b. **Tuberculosis Clinic- Department of Health-**For DYs 8-10, the state may claim FFP for expenditures otherwise uncompensated by Medicaid or third party payers that are incurred by the Tuberculosis Clinic within the Rhode Island Department of Health but are attributable to Medicaid and other low-income patients. The Tuberculosis Clinic is responsible for TB surveillance to detect cases and assures the availability of TB Specialty Clinical Services (adult and pediatric clinical services) to improve health outcomes and increase the efficiency and quality of care to all Rhode Island citizens.
- c. **Rhode Island Child Audiology Center- RI school for the Deaf-** For DYs 8-10, the state may claim FFP for expenditures otherwise uncompensated by Medicaid or third party payers that are incurred by the Rhode Island Child Audiology Center- RI School for the Deaf but are attributable to Medicaid and other low-income patients. The Audiology Center provides statewide hearing screening for children at all Rhode Island schools and will provide further diagnostic testing and referral for treatment for any child who screens at-risk for hearing loss.
- d. **Center for Acute Infectious Disease Epidemiology- RI Department of Health-** For DYs 8-10, the state may claim FFP for expenditures otherwise uncompensated by Medicaid or third party payers that are incurred by the state's Center for Acute Infectious Disease Epidemiology within the Rhode Island Department of Health and are attributable to Medicaid and other low income patients. This program conducts surveillance, clinical case review and disease investigation for reportable infectious diseases to case manage, investigate and track diseases to reduce and control infectious diseases.
- e. **Consumer Assistance Programs- Executive Office of Health and Human Services-** For DYs 8-10, the state may claim FFP for expenditures related to the two specific programs within the Consumer Assistance Programs- Executive Office of Health and Human Services:
 - i) The Office of the Child Advocates (OCA) is an independent state agency responsible for protecting the legal rights and interests of all children in state care. These rights include, but are not limited to, a child's right to healthcare and education.
 - ii) The Commission on the Deaf and Hard of Hearing. The Commission on the Deaf and Hard of Hearing (CDHH) coordinates, and provides services committed to promoting an environment in which the Deaf and Hard of Hearing in Rhode Island are afforded equal opportunity in all aspects of their lives.

85. Health Workforce Development- To promote improved access and quality of care for Medicaid beneficiaries in Rhode Island by supporting the education and training of the health care workforce

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

and to the extent that such education and training results in employment and/or continuing education of employees in settings that provide care and services in Rhode Island to Medicaid beneficiaries, the state may claim FFP for health workforce training programs and related supports at University of Rhode Island, Rhode island College and the Community College of Rhode Island. The annual limit the state may claim FFP for workforce training programs is limited to total costs, in accordance with the OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. To ensure that DSHP funds promote the development of workforce training to benefit the Medicaid population and improve access, the State shall commit to implementing the Health Workforce Development Methodology Protocol that will be Attachment R. The state shall also submit a claiming protocol specific to Health Workforce Development, Attachment S.

- 86. Intervention for AEs Failing to Fulfill Requirements or Deliverables** Upon identification of performance issues within the AEs, the state shall intervene promptly within 30 days of identifying a concern to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas identified.
- 87. Reduction in DSHP Expenditure for Failure to Fulfill requirements or Deliverables.** The table below describes the deliverables the MCOs are required to meet for the state to qualify for DSHP funding. The DSHP will be reduced in the prospective demonstration year if the MCOs did not meet the target for the previous year. The state will have an additional 15 days grace period (15 days after the due date) to fulfill requirements or submit necessary deliverables.

Table # 5 Schedule of Deliverables

| DY | Quality/Operational Improvement Targets | Due Date | % Reduction if State does not meet |
|----------------|--|-------------------|---|
| DY 8 CY 16 | <i>To ensure prompt responses to CMS' questions regarding managed care rate development, CMS is adding the following items to the state's deliverable list. EOHHS will respond in writing to CMS questions that will be provided in writing to the state, regarding their managed care capitation rate development within 4 weeks of the request by CMS. If EOHHS anticipates that responses will not be available within the timeframe, EOHHS must notify CMS in writing, within 1 week of receipt of CMS request, and request a reasonable extension, taking into account the content and volume of questions.</i> | | |
| | EOHHS Responds to all CMS questions, received prior to 10/14/2016 regarding the 2015 managed care rate certification submissions. | Dec 1, 2016 | 15% |
| | EOHHS Submits to CMS their 2016 managed care rate certification by 12/01/2016 and responds to CMS' written questions within 4 weeks of being provided questions. If EOHHS anticipates that responses will not be available within the timeframe, EOHHS must notify CMS in writing, within 1 week of receipt of CMS request, and request a reasonable extension, taking into account the content and volume of questions. | Dec 1, 2016 | 15% |
| DY 9 CY 17 | EOHHS Submits the AE Roadmap document to CMS, including AE-Specific Health Transformation Project | June 1, 2017 | 10% |
| | EOHHS Submits their DSHP Claiming Protocols; Attachment P, Attachment Q, Attachment R and Attachment S | May 15, 2017 | 15% |
| | EOHHS Submits AE Certification Standards to CMS | June 1, 2017 | 10% |
| | EOHHS Submits Attribution Guidance to CMS | October 1, 2017 | 5% |
| | EOHHS Submits APM program guidelines to CMS, includes TCOC methodology and benchmarks | October 1, 2017 | 10% |
| DY 10 CY 18 | Each MCO has at least 2 effective contracts (or 10% of covered lives) with Certified AEs in an EOHHS approved Alternative Payment Model as defined in Attachment L. | November 1, 2018 | 15% |
| | EOHHS Year 2 Guidance Posted, includes: APM Program Guidance, Attribution Guidance, and AE Incentive Program Guidance | December 15, 2018 | 5% |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

88. Specified Designated State Health Programs (DSHP). The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit and DSHP limits described in section XIII of the STCs.

Table 6: List of Approved DSHPs

| <u>Agency</u> | <u>Program Name</u> |
|--|--|
| <u>Previously Authorized Programs</u> | |
| EOHHS | Elderly Transportation Program |
| New Authorized Programs | |
| Rhode Island Department of Commerce | Wavemaker Fellowship |
| RI Department of Health | Tuberculosis Clinic |
| RI School for Deaf | Rhode Island Child Audiology Center |
| RI Department of Health | Center for Acute Infectious Disease Epidemiology |
| EOHHS | Consumer Assistance Programs |
| URI, RIC and CCRI | Health Workforce Development |

89. Marketplace Subsidy Program. Effective January 1, 2014, the state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide premium subsidies for parents and caretaker relatives of Medicaid eligible and enrolled child(ren) with incomes above 133 percent of the FPL through 175 percent of the FPL who purchase health insurance through the Marketplace. For the month of January 2014, the payments made by the Marketplace Subsidy Program may serve to create a premium holiday for beneficiaries. During the month of January 2014, the payments made by the Marketplace Subsidy Program may equal up to 100 percent of the QHP premium amount, where the premium has been reduced by any federal tax credits for which a beneficiary is eligible. Effective February 1, 2014, the payments made by the Marketplace Subsidy Program shall not exceed 50 percent of the QHP's reduced premium amount, where the premium has been reduced each month by a) any federal tax credits a beneficiary is eligible for, and b) the amount a Medicaid beneficiary would have paid as his or her Medicaid monthly premium amount as of December 31, 2013 (between \$61 and \$92 per month), as demonstrated in the formula below.

*Maximum allowable payment by Marketplace Subsidy Program = 50% * (QHP Monthly Premium – Federal Tax Credits – 12/31/2013 Medicaid Monthly Premium Amount)*

Subsidies will be provided on behalf of individuals who: (1) have a child eligible for and enrolled in RItE Care; (2) are enrolled in a Marketplace plan that does not meet RItE Share requirements; and (3) whose income is above 133 percent of the FPL and at or below 175 percent of the FPL. For example, eligible individuals could be enrolled in a high deductible Marketplace plan, as such a plan would not meet RItE Share requirements.

- a. **Funding Limit.** Expenditures for the subsidies are limited on an annual basis as follows (total computable). Expenditures for DYs 9 and 10 are contingent upon CMS approval of the evaluation report required in STC 115.

| | DY 6 | DY 7 | DY 8 | DY 9 | DY 10 |
|---|-------------|-------------|-------------|-------------|-------------|
| DSHP - State-Funded Marketplace Subsidy Limit | \$3,298,154 | \$3,021,190 | \$3,270,462 | \$3,540,302 | \$3,540,302 |

- b. **Reporting.** The state must provide data regarding the operation of this subsidy program in the quarterly report required per STC 115. This data must, at a minimum, include:
- The number of individuals served by the program each month;
 - The amount of the subsidies; and
 - A comparison of projected costs with actual costs.
- c. **Evaluation.** In DY 7 as part of the annual report, the state must evaluate the effect of the Marketplace Subsidy Program for enrollment in a QHP, using childless adults who are not eligible to receive a subsidy as a comparison group, as required per STC 115. The state must submit this report no later than May 1, 2016. CMS will evaluate the report and determine whether the state has met the requirements 60 days after receipt of the report. If the report does not meet CMS approval, federal funding for the Marketplace Subsidy Program for DYs 9 and 10 may be denied.
- d. **Budget Neutrality.** This subsidy program will be subject to the budget neutrality limit specified in STC 133.

90. Expenditures for Limited Benefit Budget Populations. Effective January 1, 2014, the state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide for a limited benefit package of supplemental services as follows:

- a. **Uninsured Adults with Mental Illness.** Effective January 1, 2014 through April 30, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental services for uninsured adults with mental illness and or substance abuse problems with incomes below 200 percent of the FPL. Effective May 1, 2014, expenditures for a state-funded program that provides a limited benefit package of

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

supplemental services for uninsured adults with mental illness and or substance abuse problems with incomes above 133 percent of the FPL and below 200 percent of the FPL who are ineligible for Medicaid.

- b. **Persons living with HIV.** Effective January 1, 2014 through April 30, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental HIV services for persons living with HIV with incomes below 200 percent of the FPL. Effective May 1, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental HIV services for persons living with HIV with incomes above 133 percent of the FPL and below 200 percent of the FPL who are ineligible for Medicaid.
- c. **Non-working disabled adults.** Effective January 1, 2014 through April 30, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental services for non-working disabled adults ages 19-64 eligible for the General Public cash assistance program. Effective May 1, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental services for non-working disabled adults ages 19-64 eligible for the General Public cash assistance program with incomes above 133 percent of the FPL, but who do not qualify for disability benefits.

XII. HEALTHY BEHAVIORS INCENTIVES PROGRAM

91. Healthy Behaviors Incentives. Subject to federal approval, the state may establish a program based on incentives: individuals who adopt healthy behaviors may be eligible for rewards, such as a gift card for health-related goods. The program may also include penalties that disincentivize unhealthy behaviors. Such program may be a part of state's efforts to reduce emergency room utilization, such as through the Communities of Care program.

92. Healthy Behaviors Incentives Protocols. The state is required to submit protocols pertaining to the program no later than 60 days after the date of this approval (Attachment H). Protocols must include, at a minimum, descriptions of the following:

- a. Populations impacted
- b. Incentives offered to beneficiaries
- c. Any penalties to disincentivize unhealthy behaviors
- d. Payment and financing methodologies, explaining which entities receive and administer funding, how incentive amounts are determined, and an explanation of any quality controls used to ensure proper use of funds.

XIII. RECOVERY NAVIGATION PROGRAM (RNP) SERVICES

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

The Recovery Navigation Program (RNP) is a non-residential (less than 24 hours), community-based recovery-oriented program that assesses, monitors, and provides case management and peer support for individuals who are under the influence of substances within a less-traumatic, less costly setting than the Emergency Department. These individuals are provided with case management in an attempt to connect them to substance use disorders (SUD) treatment and support services. Medicaid reimbursement for referral services in a RNP is limited to Medicaid enrolled beneficiaries who receive the services listed in STC 94 and from one of the qualified provider organizations that meet the requirements in STC 95 for RNP participating providers.

- 93.** On-site Medicaid-coverable RNP services are limited to services provided by a licensed EMT, LPN or RN, peer support services, and case management services furnished by providers that meet the state's qualifications for furnishing these services.
- a. RNP services will be provided by RNP practitioners, who may include an on-call physician, Registered Nurse, Licensed Practical Nurse (LPN), Emergency Medical Technician (EMT), Peer Recovery Specialist, and Case Manager practicing at an RNP participating provider defined in STC 95. These services will be within their scope of practice under state law and include services such as assessments and monitoring the health status of the individual at intake and throughout the beneficiary's participation in the RNP.
 - b. Peer support services will be provided by a Peer Recovery Specialist and include group and individual coaching, and education on the recovery process. As described in STC 107(b), Peer Recovery Specialists must meet the qualifications listed in the CMS State Medicaid Director Letter, #07-011, <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf>.
 - c. Case management services are provided by a Case Manager. A case manager will have a degree in social work, psychology, or other human service related field from an accredited college or university (there is no state level certification or licensure required). Case managers practicing at an RNP participating provider will receive all required trainings through the RNP participating provider.
 - d. Case management services are limited to identifying services appropriate for the beneficiary and referring the beneficiary to resources to obtain needed services. Referrals to these services may include, but are not necessarily limited to, substance use treatment (including medication assisted treatment, detoxification, crisis stabilization, and residential medical services); social services; and housing support services. These services will not be provided directly under the RNP; rather, case managers participating in the RNP will only link beneficiaries to the services.
 - e. Costs for services provided in an institution for mental disease (IMD) will not be eligible for federal matching funds under the RNP or as a result of a referral made under the RNP.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- f. RNP participating providers will claim payment for services provided under the RNP based on the RNP Claiming Methodology Protocol. The state must submit this protocol 60 days after the approval of the STCs and CMS has 60 days to approve the protocol. The approved protocol will be Attachment X of these STCs.
- g. Any provider delivering services through the RNP bundle will be paid through the RNP bundled payment rate and cannot bill separately. Medicaid providers delivering services outside of the RNP service bundle may bill in accordance with the state's Medicaid billing procedures.

94. RNP participating providers are organizations that do all of the following:

- a. Meet applicable state licensure requirements of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) or the Rhode Island Department of Health (DOH) for the relevant provider type;
- b. Meet state certification standards to furnish RNP services as specified on the EOHHS website.
- c. Enter into an agreement with the state that reflects all requirements for furnishing, claiming, and receiving payment for RNP services, including the referral process from EMS and other emergency responders, the monitoring requirements, tracking performance measures and reporting to the BHDDH and EOHHS, as specified in this section XIII of the STCs. The state will ensure that these agreements reflect the RNP providers' agreement to abide by these STCs and all applicable federal and state laws; and
- d. Ensure the on-site presence of all necessary practitioners to implement RNP services including a Registered Nurse, Licensed Practical Nurse, and/or Emergency Medical Technician; a Peer Recovery Specialist; and a Case Manager. These practitioners will operate within the setting established by the RNP participating provider with which they are associated and deliver the RNP services described in STC 94. An on-call physician, will be available to the RNP provider for telephonic consultation as needed. ;
- e. Administrative staff employed by the RNP participating provider will assist in the support of the program and may include, but are not limited to, a Program Manager, Medical Office Assistant, and Security personnel.

95. The state will ensure that RNP participating providers are required to facilitate and conduct necessary training for their RNP practitioners and staff on the implementation of the RNP. The state will review each RNP participating provider's curriculum to ensure the quality and consistency of the trainings. The standard trainings that the RNP participating provider, practitioners and staff

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

receive include, but is not limited to, the following, as appropriate to the person's role within the RNP:

- a. Trauma-informed care
- b. Screening and Assessments
- c. Substance Use Disorders
- d. Alcohol Use Disorder and its effects including the dangers of detoxification from alcohol
- e. Medication Assisted Treatment
- f. Ethics and Boundaries
- g. Motivational interviewing (MI) (an evidence-based treatment that addresses ambivalence about or resistance to change)
- h. Crisis intervention
- i. CPR- Cardiopulmonary Resuscitation
- j. Community resources
- k. Naloxone administration

96. The RNP is intended to promote a recovery-oriented environment and facilitate access to services to address substance use disorder without other medical complications in adults who meet the following appropriateness criteria:

- a. 18 years of age or older; the state assures that comparable services are available for SUD treatment and referrals for children under 18 years of age who do not meet the range for RNP services.
- b. Eligible for Medicaid or a Medicaid beneficiary;
- c. Have no other immediate medical needs other than substance use;
- d. Do not have any abnormal vital signs, pulse oximetry, or abnormal blood sugar levels; and
- e. Do not have any signs of physical trauma, illness, or environmental emergency.

97. The on-site RN, LPN, or EMT, will use clinical judgment after observation of the individual, and review and analyze of observable (or available) clinical information, to determine if the level of impairment warrants a transfer to the emergency department (ED). If the on-site practitioner determines that the individual's medical condition requires emergent medical care, the individual will be transported by EMS to the ED. If the clinical staff determines that the individual does not require emergent medical care but that RNP services are not appropriate for the individual, alternative arrangements and referrals will be made by the RNP case manager.

Individuals will be able to access the RNP through any number of referral sources including, but not limited to, Peer Recovery Specialists, Outreach Workers, community agencies, physicians, family, and self-referrals. The RNP participating providers will establish Memoranda of Agreements (MOAs) with other local medical providers and organizations (including the Rhode Island Department of Health, Center for Emergency Preparedness and

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

Response (CEPR), which coordinates education and support services for public safety agencies and the general public), and will utilize an EOHHS approved standard screening tool, found in Attachment X, to determine if RNP services are appropriate for an individual. These MOAs will include the content described in Attachment W.

98. Individuals may be transported to the RNP participating provider via Emergency Medical Services (EMS) and law enforcement. Prior to transport, the emergency responder will conduct an initial screening to determine if referral to an RNP participating provider for RNP services is appropriate, using the screening tool found in Attachment X.
99. If possible, all referral sources will notify the RNP participating provider of the pending arrival of an individual. Regardless of referral source or prior notification, individuals will be received by clinical staff of the RNP participating provider.
 - a. The individual will be brought to the triage area for a full assessment performed by RN, LPN, or EMT, who prioritizes the determination of the state of intoxication, potential for increased intoxication, and risk for withdrawal using the Clinical Institute Withdrawal Assessment (CIWA) and Clinical Opiate Withdrawal Scale (COWS). Vital signs and Blood Alcohol Level (BAL) are also collected. In the event an individual has been transported by an emergency responder, these screenings/assessments are all conducted prior to the emergency responder leaving the RNP participating provider's site. This is to ensure that the individual is served in the clinically appropriate setting.
 - b. Once RNP services are determined to be appropriate for the individual by clinical staff, ongoing assessments of vital signs, BAL, COWS, and CIWA, will be conducted as appropriate. The RNP participating provider will use the Patient Health Questionnaire-9 (PHQ-9) to document any concerns of depression, and/or thoughts of harming oneself.
 - c. Any non-emergent mental health issue that may be identified by the RNP participating provider would be addressed through the RNP referral process for additional assistance. The presence of peripheral mental health issues does not exclude participants so long as they meet the appropriateness criteria for RNP services.

100. Requirements Related to Program Monitoring:

- a. The RNP participating provider shall provide BHDDH and EOHHS with information needed to monitor compliance, quality improvement, and effective clinical care.
- b. The RNP participating provider shall provide BHDDH and EOHHS with an outcome-oriented quarterly progress report, in addition to meeting the performance measure reporting requirements, as detailed below in STC 103
- c. The RNP participating provider shall meet with BHDDH and EOHHS personnel to discuss operational and policy matters related to any services provided under the RNP participating

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

provider agreement including, but not limited to, performance on issues of access, continuity of care, and development and implementation of the RNP.

- d. Any requested amendments to the RNP participating provider agreement, and any contracts related to the provider's participation in the RNP (including with respect to the services agreed to be provided by the RNP participating provider and/or by any contractor of the RNP participating provider), must be submitted in writing to BHDDH and EOHHS for review and approval prior to implementation. EOHHS must submit requested changes to the permissible RNP services identified in STC 94 to CMS and must receive CMS approval before any such changes are implemented within the RNP.
- e. Prior to releasing the individual, the RNP participating provider must attempt to collect client feedback from the individual to help ensure quality of services in the form of a consumer satisfaction survey.
- f. The RNP participating provider (and, if applicable, any contractors of the RNP participating provider), must maintain a detailed, comprehensive record of all services provided under the program.
 - g. The RNP participating provider must provide at least two hours per month or 30 minutes per week of documented supervision to all Peer Recovery Specialists, and Case Managers, administered by an appropriately licensed healthcare professional. The RNP provider must adhere to all applicable Rhode Island General Laws and Code of Regulations regarding supervision of on-call physician, Registered Nurses, Licensed Practical Nurses (LPN), and Emergency Medical Technicians (EMT).

101. Performance Measures

The RNP participating provider is required to submit data at monthly intervals to BHDDH and EOHHS via secure electronic files of client-level records for all individuals receiving RNP services, as outlined in STC 94.

- a. The RNP participating provider monthly reporting will include the minimum requirements below and submitted in the format required by the state:
 - 1) Number of unduplicated clients served;
 - 2) Number of Medicaid beneficiaries assessed for RNP admission;
 - 3) Number of individuals eligible for Medicaid but not an enrolled Medicaid beneficiary at the time of RNP service assessed for specific RNP services during reporting period (reporting should be done per RNP service); For each client, date and time of entry into the program;
 - 4) Number of clients that upon assessment with RNP, self-reported a mental health issue or co-occurring disorders;
 - 5) Number of clients with self-reported current medical conditions;
 - 6) Patient demographics (SSN, age, gender, ethnicity, city of residency);
 - 7) Historical substance(s) used;
 - 8) Number of clients referred for additional services, including detoxification or crisis stabilization unit (reporting should be done per referral service)
 - 9) Number of clients that continue to work with the peer recovery support team, 3, 6 and 12 months after referral;

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- 10) Number of clients sent to the ED from RNP because of an RNP practitioner determination that ED services were clinically required;
- 11) Source of referral to RNP (EMS, self-referral, police, Peer Recovery Specialists, ED, other hospital department, etc., with number of referrals reported by source);
- 12) Number of clients referred for application to other social/health/human services benefit programs, such as Low Income Heat Energy Assistance Program (LIHEAP), Medicaid (if not an enrolled beneficiary), Rhode Island RItE Care (SCHIP) Benefits, Women, Infants and Children Program (WIC), Supplemental Nutrition Assistance Program (SNAP), Unemployment, RI Works.
- 13) The RNP participating provider shall provide quarterly progress report narratives including any obstacles to successful implementation of the RNP and steps taken or planned to address such obstacles, which narratives shall be informed by client feedback regarding quality of services. This data will be crossed with Medicaid claims data and Behavioral Health On-Line Database of admission, discharge and outcome data to determine if the total cost of care for individuals receiving interventions under the RNP is reduced or increased, if hospital admissions are decreased, and if they make inroads to recovery through engagement in treatment, increased stability in housing, reduction in substance use and other outcome measures as collected through the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Outcome measures.

XIV. PEER RECOVERY SPECIALIST

- 102.** A Peer Recovery Specialist (PRS) will be a credentialed behavioral health care professional as described in STC 105 who provides an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connections to the community. The Peer Recovery Specialists will offer peer services that will focus on people with a mental health and/or substance use disorder who are having trouble stabilizing in the community and/or are in need of supports to maintain their stability in the community. This includes but is not limited to Medicaid-eligible individuals who are experiencing, or are at risk of, hospitalization, overdose, homelessness or are in the hospital after an overdose, are homeless or are in a detox setting. It would also include people recently released from institutions such as hospitals and prisons.
- 103.** The Peer Recovery Specialist's role is to bring to the beneficiary, a unique vantage point and the skills of someone who has succeeded in managing a serious behavioral health condition or developmental disability, or is an adult with an on-going and/or personal experience with a family member with a similar mental illness and/or substance use disorder. The key objective of this position is to provide individuals with a support system to develop and learn healthy living skills. Recovery support services are expected to help prevent relapse, reduce the severity of a disability, improve and restore function and promote long-term recovery. Services include peer support to foster encouragement of personal responsibility and self-determination, tools and education to focus on health and wellness and skills to engage and communicate with providers and systems of care.

- 104.** The Peer Recovery Specialists will work under the direction of a licensed health care practitioner or a non-clinical PRS Supervisor. Non-clinical PRS Supervisors must be certified as a PRS and worked at least 2 years providing PRS services. A Peer Recovery Specialist may work under the supervision of a RNP participating provider. Peer Recovery Specialist services that are provided through the RNP will be paid through the RNP bundled payment rate and may not be separately billed. Peer Recovery Specialist services that are not provided through the RNP must be billed by a Medicaid-enrolled provider of services through standard claiming procedures, and will be paid a flat fee for all services provided to a given Medicaid beneficiary.
- 105.** In addition to providing wellness supports, the PRS utilizes his or her own experiences to act as a role model, teacher, and guide who both encourages and empowers the beneficiary to succeed in recovery and leading a healthy productive lifestyle.
- 106.** Specific other examples of PRS work include, but are not limited to, the following:
- a. Supporting individuals in accessing community-based resources; recovery, health and wellness supports; and employment services;
 - b. Guiding individuals in developing and implementing recovery, health and wellness, and employment plans. Serving as a role model for the integration of recovery, health and wellness, and employment;
 - c. Educating individuals regarding services and benefits available to assist in transitioning into and staying in the workforce;
 - d. Navigating state and local systems (including addiction and mental health treatment systems);
 - e. Mentoring individuals as they develop strong foundations in recovery and wellness;
 - f. Promoting empowerment and a sense of hope through self-advocacy by sharing personal recovery experiences;
 - g. Serving as an integral member of an individual's recovery and wellness team.
- 107.** A prospective Peer Recovery Specialist must meet the following criteria:
- a. Credentialed by the Rhode Island Certification Board (RICB) as a Peer Recovery Specialist, pursuant to the standards available at <http://www.ricertboard.org/>. RICB credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&RC).
 - b. Peer support services will be provided by a Peer Recovery Specialist and include group and individual coaching, and education on the recovery process. Peer Recovery Specialists must meet the qualifications in the CMS State Medicaid Director Letter, #07-011, <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf>.
 - c. Acknowledges a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and has received or is currently receiving treatment and/or community support for it. People who have experience with an on-going and/or personal experience with a family member with a similar mental illness and/or substance use disorder are also qualified to be a PRS.

- d. The service is restorative in nature for individuals with mental health and/or substance use disorders needing support to maintain stability in the community. PRS operate under a “Recovery Oriented Systems of Care” model. They use a strengths-based approach with the primary goal being to assist individuals in achieving sustained recovery and restoration.
- e. Reporting and Monitoring- Consumer Surveys as well as focus groups and outreach in the community will be used to collect information about the effectiveness of the PRS. The Consumer Survey is administered to identified potential clients during the first contact, and then at 6 months and 1 year. BHDDH, through a contract with a local community agency, will be doing outreach to and focus groups for populations with additional challenges including but not limited to: housing instability; socioeconomic status; employment issues; people transitioning from prison to community; those with transportation issues; and parents involved with child welfare system to get their input regarding peer recovery services. Information gleaned from the focus groups, surveys, and outreach will be used to improve PRS training and service delivery.
- f. The Peer Recovery Specialist Training Curriculum must meet the Rhode Island Certification Board standards.

XV. GENERAL REPORTING REQUIREMENTS

- 108. General Financial Requirements.** The state must comply with all general financial requirements under title XIX and title XXI set forth in sections XVII and XVII respectively.
- 109. Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR 438 *et. seq.* except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.
- 110. Reporting Requirements Relating to Budget Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality as set forth in section XVIII.
- 111. Title XXI Reporting Requirements.** The state will provide to CMS on a quarterly basis, an enrollment report for the title XXI populations showing end of quarter actual and unduplicated ever enrolled figures. This data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter.
- 112. Confirmation of CHIP Allotment with the Submission of CHIP State Plan Amendments.** Should the state seek an amendment under the CHIP state plan that has a budgetary impact on allotment neutrality, the state shall submit an updated allotment neutrality budget with the CHIP state plan amendment for CMS review and approval.
- 113. Quarterly Calls.** CMS shall schedule quarterly conference calls with the state for the duration of the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to,

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the demonstration. The state must inform CMS of any changes it anticipates making to the demonstration as a Category I, II, or III change. The state and CMS shall jointly develop the agenda for the calls.

114. Quarterly Operational Reports. The state must submit quarterly progress reports in the format specified in Attachment E no later than 60 days following the end of each quarter.

The intent of these reports is to present the State's analysis and the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

- a. Updated budget neutrality and allotment neutrality monitoring spreadsheets;
- b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery including approval and contracting with new plans; benefits; cost-sharing, enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the demonstration; pertinent legislative activity; and other operational issues;
- c. Action plans for addressing any policy and administrative issues identified;
- d. Any changes the state made or plans to make to the demonstration as a Category I or II change;
- e. The number of individuals enrolled in each major program of the Comprehensive demonstration; including, but not limited to TANF and related programs, the extended family planning program; each of the limited benefit programs; and ABD with breakouts for the LTC reform community and institutional programs;
- f. The number of individuals served by and costs of the Marketplace Subsidy program; and
- g. Evaluation and Quality Assurance and Monitoring activities and interim findings.

115. Annual Report. The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under STC 116. The state shall submit the draft annual report no later than 120 days following the end of the demonstration year (May 1st). Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

The annual report for year 3 of the demonstration shall include an evidence package that CMS can use to conduct a quality review of the State's Home and Community-Based Services system operated under the demonstration. This review will be similar to the quality review currently conducted on all section 1915(c) waivers and will be used to evaluate the overall performance of the HCBS program and to identify the need for any modifications or technical assistance necessary to continue successful operation of the program. Attachment G is a listing of the types of evidence-based information CMS must review in order to determine the State's implementation of its quality management and improvement strategy – that is discovery, remediation, and improvement activities with regard to HCBS waiver assurances. After reviewing the evidence package, the CMS Regional Office will contact the state staff to discuss necessary follow-up activities.

For DY 7, the state must present an evaluation of the impact of the Marketplace Subsidy Program on QHP enrollment trends. The evaluation must address the following questions:

- How many parents/caretaker adults with incomes between 133 and 175 percent of the FPL have taken up QHP coverage with the assistance of the Marketplace Subsidy Program?
- How many childless adults with incomes between 133 and 175 percent of the FPL have taken up QHP coverage?
- Do enrollment trends in QHPs differ significantly between parents/caretaker adults and childless adults with incomes between 133 and 175 percent of the FPL?
- Based on the findings of this evaluation, please explain the state's recommendations for the future of the Marketplace Subsidy Program.

As a part of the Annual reports for Demonstration Years 8, 9 and 10, the State must collect and report data on the tracking of the following items for the Workforce Development DSHP project. Per Attachment R, tracking and reporting will include:

- Number of graduates of each health professional training program for which FFP is claimed, within University of Rhode Island, Rhode Island College and the Community College of Rhode Island
- Number of Graduates of each program/professional type (e.g. reporting will distinguish between physicians, nurses, dentists, physical therapists, and so on) and by practitioner specialty to the extent possible.
- These data will be presented in a detailed annual report. Updates will be provided quarterly, as available.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

As a part of the Annual reports for Demonstration Years 8, 9 and 10, the State must collect and report data from the Commerce Corporation's existing database on the tracking of the following items for the Wavemaker DSHP project. Per Attachment Q, tracking and reporting will include:

- Number of Fellowship awardees and the estimated volume of Medicaid patients served by each awardee each year.
- Number of Fellowship awardees who have fulfilled their annual work commitment by working with a Medicaid provider serving Medicaid members and description of specific health care/medical job (job placement and employer information) in RI for each Fellowship awardee.
- These data will be presented in a detailed annual report. Updates will be provided quarterly, as available.

In addition, as part of the Annual reports for Demonstration Years 8, 9 and 10, the State must analyze whether support for DSHP programs resulted in a net increase in state spending (adjusted for inflation) in federally matched state expenditures.

XVI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

116. Quarterly Expenditure Reports. The state shall provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section XVIII.

117. Reporting Expenditures Under the Demonstration. In order to track expenditures under this demonstration, Rhode Island must report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Expenditures for optional targeted low income children (CHIP Children) claimed under the authority of title XXI shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS 64.21UP Waiver.

- a. For the extended family planning component of the demonstration, the state should report demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:
 - i. Allowable family planning expenditures eligible for reimbursement at the State's Federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.
- b. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns (A) and (B). Additionally, the total amounts that are attributable to the demonstration must be separately reported on the CMS-64 Narrative by demonstration year.
- c. For each demonstration year, twenty eight (28) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following demonstration populations and demonstration services. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in the second column of the tables below, labeled “CMS-64 Eligibility Group Reporting.” Expenditures should be allocated to these forms based on the guidance found below.

| <i>Demonstration population number</i> | <i>CMS-64 Eligibility Group Reporting</i> | <i>PMPM Grouping for Without Waiver Budget Neutrality Worksheets</i> |
|---|--|---|
| Budget Population 1 | ABD no TPL | ABD no TPL |
| Budget Population 2 | ABD TPL | ABD TPL |
| Budget Population 3 | Rlte Care | Rlte Care |
| Budget Population 4 | CSHCN | CSHCN |
| Budget Population 14 | BCCTP | ABD no TPL, ABD TPL |
| Budget Population 22 | New Adult Group | Low-Income Adult Group |

| <i>Demonstration population number</i> | <i>CMS-64 Eligibility Group Reporting</i> | <i>PMPM Grouping for Without Waiver Budget Neutrality Worksheets</i> |
|--|---|--|
| Budget Population 7 | CHIP Children | RIte Care |

| <i>Demonstration population number</i> | <i>CMS-64 Eligibility Group Reporting</i> | <i>PMPM Grouping for Without Waiver Budget Neutrality Worksheets</i> |
|--|---|--|
| Budget Population 5 | EFP | Family Planning Group |
| Budget Population 6 | Pregnant Expansion | RIte Care |
| Budget Population 8 | Substitute care | CSHCN |
| Budget Population 9 | CSHCN Alt | CNOM |
| Budget Population 10 | Elders 65 and over | CNOM |
| Budget Population 11 | 217-like group | 217-like Group |
| Budget Population 12 | 217-like group | 217-like Group |
| Budget Population 13 | 217-like group | 217-like Group |
| Budget Population 15 | AD Risk for LTC | CNOM |
| Budget Population 16 | Adult Mental Unins | CNOM |
| Budget Population 17 | Youth Risk Medic | CNOM |
| Budget Population 18 | HIV | CNOM |
| Budget Population 19 | AD Non-working | CNOM |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| <i>Demonstration population number</i> | <i>CMS-64 Eligibility Group Reporting</i> | <i>PMPM Grouping for Without Waiver Budget Neutrality Worksheets</i> |
|--|---|--|
| Budget Population 20 | Alzheimer adults | CNOM |
| Budget Population 21 | Beckett aged out | CNOM |

| <i>Demonstration services number</i> | <i>CMS-64 Eligibility Group Reporting</i> | <i>PMPM Grouping for Without Waiver Budget Neutrality Worksheets</i> |
|--------------------------------------|---|--|
| Budget Services 1 | Windows | CNOM |
| Budget Services 2 | RIteShare & Colltns | RIte Care |
| Budget Services 3 | Other Payments | RIte Care |
| Budget Services 4 | Core Preventive Services | CNOM |

d. Specific Reporting Requirements for Budget Population 7.

- i. The state is eligible to receive title XXI funds for expenditures for this demonstration population, up to the amount of its title XXI allotment (including any reallocations or redistributions). Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver in accordance with the instructions in section 2115 of the state Medicaid Manual.
- ii. Title XIX funds are available under this demonstration if the state exhausts its title XXI allotment (including any reallocations or redistributions). If the state exhausts its available title XXI funds prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver and will be considered expenditures subject to the budget neutrality agreement as defined in paragraph 118.

e. Description of Budget Services.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- i. Budget Services 1 [Windows]. Cost of replacement windows in residences of lead poisoned eligibles.
- ii. Budget Services 2 [RIteShare & Colltns]. Premiums paid by state for ESI coverage and premiums paid by RIte Care enrollees.
- iii. Budget Services 3 [Other Payments]. Payments to health plans for performance incentives; risk sharing; and stop loss, as well as FQHC supplemental payments.
- iv. Budget Services 4 [Core Preventive Services]. Core and preventive services for Medicaid-eligible at-risk youth.

118. Expenditures Subject to the Budget Neutrality Agreement. For purposes of this section, the term “expenditures subject to the budget neutrality agreement” means expenditures for all medical assistance payments except DSH, the phased-down Part D contributions and LEA payments. Such expenditures include all expenditures that are described in paragraph 117. Payments for medical assistance for emergency services for non-qualified aliens are subject to the budget neutrality agreement. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms 64.9 Waiver and/or 64.9P Waiver.

119. Premium Collection Adjustment. The state must include demonstration premium collections as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis on the budget neutrality monitoring spreadsheet.

120. Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

121. Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

122. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

- a. For the purpose of monitoring the budget neutrality agreement and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 114, the actual number of eligible member months for all Budget Populations defined in paragraph 117. The

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

state must submit a statement certifying the accuracy of this information accompanying the quarterly report.

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

- b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

123. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. Rhode Island must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality agreement and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

124. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in section XVIII:

- a. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- b. Net medical assistance expenditures made under section 1115 demonstration authority with dates of service during the demonstration period.

125. Extent of Federal Financial Participation for the Extended Family Planning Program. CMS shall provide Federal Financial Participation (FFP) for CMS-approved services (including prescriptions) provided to women under the extended family planning program at the following rates and as described in Section X of these STCs.

- a. For procedures or services clearly provided or performed for the primary purpose of family planning (contraceptives and sterilizations) and which are provided in a family planning setting, FFP will be available at the 90 percent Federal matching rate. Procedure codes for office visits, laboratory tests, and certain other procedures must carry a diagnosis that specifically identifies them as a family planning service.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- b. Family planning-related services reimbursable at the Federal Medical Assistance Percentage (FMAP) rate are defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided because a “family planning-related” problem was identified/ diagnosed during a routine/periodic family planning visit. Services/surgery, which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center, or a hospital for family planning-related services, are not considered family planning-related services and are not covered under the demonstration.
- c. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for sexually transmitted infections as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. Subsequent treatment would be paid for at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.
- d. CMS will provide FFP at the appropriate 50 percent administrative match rate for general administration costs, such as, but not limited to, claims processing, eligibility assistance and determinations, outreach, program development, and program monitoring and reporting.

126. Sources of Non-Federal Share. Rhode Island certifies that the matching non-federal share of funds for the demonstration is state/local monies. Rhode Island further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. Premiums paid by enrollees and collected by the state shall not be used as a source of non-federal share for the demonstration. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. Rhode Island agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require Rhode Island to provide information to CMS regarding all sources of the non-Federal share of funding.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

If the state pays the Managed Care Organizations at a rate which has not been approved by CMS, the state will agree to reconcile these payments to be in accordance with the final rates that are approved by CMS.

127. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame

XVII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

128. Quarterly Expenditure Reports. In order to track title XXI expenditures under this demonstration, the state must report quarterly demonstration expenditures through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in sections 2115 and 2500 of the state Medicaid Manual. Eligible title XXI demonstration expenditures are expenditures for services provided to title XXI children who are eligible with FPL levels within the approved CHIP state plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the State's available title XXI funding.

Title XXI expenditures must be reported on separate Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

129. Claiming Period. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the Form CMS-21 net expenditures related to dates of service during the operation of the section 1115 demonstration.

130. Standard CHIP Funding Process. The standard CHIP funding process will be used during the demonstration. Rhode Island must estimate matchable expenditures for CHIP Children and Pregnant Women between 185 percent and 250 percent of the FPL on the quarterly Form CMS-37.12 (Narrative) for both Medicaid Assistance Payments (MAP) and state and local Administrative costs (ADM). CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 waiver forms with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

131. Limit on Title XXI Funding. Rhode Island will be subject to a limit on the amount of Federal title XXI funding that the state may receive on demonstration expenditures during the demonstration

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including any redistributed funds. Should the state expend its available allotment and redistribution, no further enhanced Federal matching funds will be available for the expenditures for demonstration Populations 6 and 7 until the next allotment becomes available. Once all available title XXI funds are exhausted, the state will continue to provide coverage to Demonstration Population 6 and 7 and is authorized to claim Federal funding under title XIX funds (title XIX funds are not available for the separate program) until further title XXI Federal funds become available. The state must request a Category II change per the process outlined in STC 18 and notify CMS of its intent to exercise its authority to cover Population 7 using title XIX funds. When title XXI funds are exhausted Population 7 derives its eligibility through the costs not otherwise matchable authority under the demonstration and will be considered a title XIX expenditure.

132. Limit on Administrative Costs. Total expenditures for outreach and other reasonable costs to administer the title XXI state plan and for the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total expenditures.

XVIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

133. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. For the first five years of the demonstration, the limit was set at an aggregate amount of \$12.075 billion (total computable), and beginning January 1, 2014, the limit is determined by using a per capita cost method. Budget neutrality expenditure limits are set on a yearly basis based on calculated member months with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

134. Risk. Effective January 1, 2014, the state will be at risk for the per capita cost for demonstration populations as defined in STC 20, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

135. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration beginning January 1, 2014, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 125.a. below. The annual limits will then be added together with the prior aggregate cap amount (\$12.075 billion) to obtain a budget neutrality limit for the entire demonstration period. The Federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The Federal share of this limit

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share 1, which is defined in STC 141 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (ABD Adults No TPL, ABD Adults TPL, Rite Care, CSHCN), plus any excess spending from the Supplemental Tests described in STCs 139 and 140.

136. Per Capita Budget Neutrality Limit and Aggregate Adjustment. For each DY, separate annual budget limits of demonstration service expenditures will be calculated. Each annual budget limit will have per capita and aggregate components.

- a. Per capita limits. The per capita component is determined as the sum of the products of the trended monthly per person cost times the actual number of eligible/member months, as reported to CMS by the state under the guidelines set forth in STC 124. The trend rates and per capita cost estimates for each MEG for each year of the demonstration are listed in the table below.

| MEG | Trend Rate | DY 6 (CY 2014) | DY 7 (CY 2015) | DY 8 (CY 2016) | DY 9 (CY 2017) | DY 10 (CY 2018) |
|-------------------|------------|-------------------|-------------------|-------------------|-------------------|--------------------|
| ABD Adults No TPL | 4.3% | \$2,667 | \$2,781 | \$2,899 | \$3,023 | \$3,152 |
| ABD Adults TPL | 4.3% | \$3,016 | \$3,144 | \$3,278 | \$3,417 | \$3,563 |
| Rite Care | 5.2% | \$455 | \$479 | \$504 | \$530 | \$558 |
| CSHCN | 5.0% | \$2,689 | \$2,825 | \$2,967 | \$3,116 | \$3,273 |

- b. Aggregate adjustments. This adjustment will be calculated in the following way: The previous period's (DY1-5) actual demonstration expenditures will be subtracted from the demonstration's aggregate cap for DY 1-5 to determine budget neutrality carryforward savings (\$12.075 billion). This amount will then be added to the per capita limits for the next demonstration period (DY6-10) to determine the cumulative budget neutrality limit for the demonstration.

137. Supplemental Budget Neutrality Test 1: Hypothetical Groups. Effective January 1, 2014, the budget neutrality test for this demonstration includes an allowance for hypothetical populations, which are optional populations that could have been added to the Medicaid program through the state plan, but instead will be covered in the demonstration only. The expected costs of hypothetical populations are reflected in the "without-waiver" budget neutrality expenditure limit. The state must not accrue budget neutrality "savings" from hypothetical populations. To accomplish these goals, a separate expenditure cap is established for the hypothetical groups, to be known as Supplemental Budget Neutrality Test 1.

- a. The MEGs listed in the table below are for the Supplemental Budget Neutrality Test 1.

| MEG | Trend Rate | DY 6 (CY 2014) | DY 7 (CY 2015) | DY 8 (CY 2016) | DY 9 (CY 2017) | DY 10 (CY 2018) |
|----------------|------------|-------------------|-------------------|-------------------|-------------------|--------------------|
| 217-like Group | 3.1% | \$3,629 | \$3,735 | \$3,848 | \$3,968 | \$4,095 |

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

| | | | | | | |
|------------------------------|------|------|------|------|------|------|
| Family Planning Group | 5.3% | \$19 | \$20 | \$21 | \$22 | \$23 |
|------------------------------|------|------|------|------|------|------|

- b. The Supplemental Cap 1 is calculated by taking the PMPM cost projection for each group in the above table in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The Federal share of Supplemental Cap 1 is obtained by multiplying the total computable Supplemental Cap 1 by Composite Federal Share 2.
- c. Supplemental Budget Neutrality Test 1 is a comparison between the Federal share of Supplemental Cap 1 and total FFP reported by the State for hypothetical groups under the MEG “217-like group” described in STC 119
- d. If total FFP for hypothetical groups should exceed the Federal share of Supplemental Cap 1, the difference must be reported as a cost against the budget neutrality limit described in paragraph 119.

138. Monitoring of New Adult Group Spending and Opportunity to Adjust Projections. For each DY, a separate annual budget limit for the new adult group will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in STC 124. The trend rates and per capita cost estimates for the new adult group are listed in the table below.

| MEG | Trend Rate | DY 6 – PMPM | DY 7 - PMPM | DY 8 - PMPM | DY 9 - PMPM | DY 10 - PMPM |
|------------------------|-------------------|--------------------|--------------------|--------------------|--------------------|---------------------|
| New Adult Group | 5.1% | \$773 | \$813 | \$855 | \$899 | \$945 |

- a. If the state’s experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the new adult group PMPM limit described above may underestimate the actual costs of medical assistance for the new adult group, the state has the opportunity to submit an adjustment the PMPM limit, along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 6. In order to ensure timely adjustments to the PMPM limit for a demonstration year, the revised projection must be submitted to CMS by no later than the end of the third quarter of the demonstration year for which the adjustment would take effect.
- b. The budget limit for the new adult group is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.
- c. The state will not be allowed to obtain budget neutrality “savings” from this population.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- d. If total FFP reported by the state for the new adult group should exceed the federal share of FFP for the budget limit for the new adult group by more than 3 percent following each demonstration year, the state must submit a corrective action plan to CMS for approval.

139. Composite Federal Share Ratios. The Composite Federal Share is the ratio calculated by dividing the sum total of Federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There are three Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures reported under the MEGs listed in STC 138 (which are further defined by demonstration group in STC 138; Composite Federal Share 2, based on the expenditures reported under the “217-like group” MEG, defined in STC 139 and Composite Federal Share 3, based on the expenditures reported under the “New Adult Group” MEG, defined in STC 140. Should the demonstration be terminated prior to the end of the extension approval period (see STC 10), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

140. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

141. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, if the state’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

| Demonstration Year | Cumulative Target Definition | Percentage |
|--------------------|--|-------------|
| DY 6 | Cumulative budget neutrality limit plus: | 2.0 percent |
| DY 7 | Cumulative budget neutrality limit plus: | 1.5 percent |
| DY 8 | Cumulative budget neutrality limit plus: | 1.0 percent |
| DY 9 | Cumulative budget neutrality limit plus: | 0.5 percent |

| Demonstration Year | Cumulative Target Definition | Percentage |
|--------------------|--|------------|
| DY 10 | Cumulative budget neutrality limit plus: | 0 percent |

142. Exceeding Budget Neutrality. If the cumulative budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess Federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XIX. EVALUATION OF THE DEMONSTRATION/ QUALITY ASSURANCE AND QUALITY IMPROVEMENT

143. 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 120 days after award of the demonstration. The state must submit to CMS for approval any changes to the evaluation design due to additional components in the demonstration no later than 90 days after amendment approval. CMS has 60 days to review the updated evaluation design. The evaluation must outline and address evaluation questions for both of the following components:

- a. Rhode Island Comprehensive Demonstration. 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:
 - i. LTC Reform, including the HCBS-like and PACE-like programs;
 - ii. RItE Care;
 - iii. Rite Share;
 - iv. The section 1115 Expansion Programs (Limited Benefit Programs), including but not limited to:

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- (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 mental illness/substance abuse problems;
- (6) Coverage of detection and intervention services for at risk young children;
- (7) HIV Services;
- (8) The Marketplace Subsidy Program

144. Accountable Entity Roadmap. The Accountable Entity Roadmap will be a conceptualized living document that will be updated annually to ensure that best practices and lessons are learned throughout implementation, that can be leveraged and incorporated into the State's overall vision of delivery system reform. The state must submit annually the Accountable Entity Roadmap outlined in STC #48. The document must contain elements of STC #48 a-n.

145. Interim Evaluation of the Marketplace Subsidy Program. The state must submit an interim evaluation of the Marketplace subsidy program to CMS by September 1, 2014 that meets the requirements of the CMS-approved evaluation design. The state must evaluate the number of individuals who participate in the program compared against the number of individuals who were enrolled in Rite Care and Rite Share in December 31, 2013. The state must evaluate whether and how the change in the premium subsidy affected enrollment.

146. Interim Evaluation of the Accountable Entities Program. The state must submit an interim evaluation of the Accountable Entities program to CMS by December 1, 2018 that meets the requirements of the CMS-approved evaluation design. The state must evaluate the number of Certified Accountable Entities that participate in the program and the benchmarks used for the final evaluation of the effectiveness of the AEs.

147. Interim Evaluation Reports. In the event the state requests an extension of the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the State's request for each subsequent renewal.

148. Final Evaluation Design and Implementation.

- a. CMS must provide comments on the draft evaluation design within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments.
- b. The state must implement the evaluation design and submit its progress in each quarterly operational and annual report.

- c. The state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments.

149. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration, the state must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration.

XX. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

| Date - Specific | Deliverable | STC Reference |
|---|--|-----------------------------|
| 120 days after award of the demonstration | Submit Draft Evaluation Plan, including the Extended Family Planning program | Section XIX, paragraph 145 |
| September 1, 2014 | Interim Evaluation of Marketplace Subsidy Program | Section XIX, paragraph 147 |
| December 1, 2018 | Interim Evaluation of Accountable Entities Program | Section XIX, paragraph 148 |
| Annual | By May 1st - Draft Annual Report | Section XV, paragraph 117 |
| Quarterly | CHIP Enrollment Reports | Section XV, paragraph 113 |
| | Operational Reports | Section XV, paragraph 116 |
| | Title XIX Expenditure Reports | Section XVI, paragraph 118 |
| | Title XXI Expenditure Reports | Section XVII, paragraph 130 |
| | Eligible Member Months | Section XVI, paragraph 124 |

ATTACHMENT A – Additional Benefits

These benefits are not provided under the Rhode Island Medicaid State Plan, but only under the demonstration and for persons enrolled in either managed care or fee-for-service delivery systems.

| |
|--|
| Nutrition services |
| Individual/group education, parenting and childbirth education classes |
| Tobacco cessation services for non-pregnant beneficiaries |
| Window replacement for lead-poisoned children |
| Complementary alternative medicine services to a subset of enrollees with chronic pain diagnoses |

ATTACHMENT B - Core and Preventive Home and Community-based Service Definitions

CORE SERVICES

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

Environmental Modifications (Home Accessibility Adaptations): Those physical adaptations to the home of the member or the member's family as required by the member's service plan, that are necessary to ensure the health, welfare, and safety of the member or that enable the member to attain or retain capability for independence or self-care in the home and to avoid institutionalization, and are not covered or available under any other funding source. A completed home assessment by a specially trained and certified rehabilitation professional is also required. Such adaptations may include the installation of modular ramps, grab-bars, vertical platform lifts and interior stair lifts. Excluded are those adaptations that are of general utility, and are not of direct medical or remedial benefit to the member. Excluded are any re-modeling, construction, or structural changes to the home, i.e. (changes in load bearing walls or structures) that would require a structural engineer, architect and/or certification by a building inspector. Adaptations that add to the total square footage of the home are excluded from this benefit. All adaptations shall be provided in accordance with applicable state or local building codes and prior approved on an individual basis by the EOHHS Office of Long Term Services and Supports is required. Items should be of a nature that they are transferable if a member moves from his/her place of residence.

Special Medical Equipment: Specialized Medical Equipment and supplies to include Ceiling or Wall Mounted Patient Lift, Track System, tub slider system, rolling shower chair and/or Automatic Door Opener, which enable a member to increase his/her ability to perform activities of daily living, including such other durable and non-durable medical equipment not available under the Medicaid-funded primary and acute care system that is necessary to address participant functional limitations. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid-funded primary and acute care system and exclude those items that are not of direct medical or remedial benefit to the member. Medical equipment funded under the primary and acute care system includes items such as wheel chairs, prosthetics, and orthotics. These services that were provided under the authority of the Rhode Island State Plan prior to the 1115 Waiver approval. These items are still available under the 11115 Waiver and are described on the EOHHS website. All items shall meet applicable standards of manufacture, design and installation. Provision of Special Medical Equipment requires prior approval on an individual basis by the

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

EOHHS, Office of Long Term Services and Supports and a home assessment completed by a specially trained and certified rehabilitation professional. Items should be of a nature that they are transferable if a member moves from his/her place of residence. Excluded are any re-modeling, construction, or structural changes to the home, (i.e. changes in load bearing walls or structures) that would require a structural engineer, architect and/or certification by a building inspector.

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

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

Personal Emergency Response (PERS): PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center, as specified by Center for Adult Health contract standards. This service includes coverage for installation and a monthly service fee. Providers are responsible to insure the upkeep and maintenance of the devices/systems.

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

Community Transition Services: Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

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

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

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

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

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

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

Private Duty Nursing: Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of state law and as identified in the Individual Service Plan (ISP). These services are provided to an individual at home and require an assessment to be completed by a Registered Nurse (RN) from the Office of Community Programs.

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

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

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

Senior Companion (Adult Companion Services): Non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise the participant with
Rhode Island Comprehensive Demonstration
Demonstration Approval Period: December 23, 2013 through December 31, 2018
Amended September 24, 2018

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

Assisted Living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility; but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to an individual who resides in his/her own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms, and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other unit. The facility must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living room or dining room). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and must treat each person with dignity and respect. Costs of room and board are excluded from payments for assisted living services.

Personal Care Services: Personal Care Services provide direct support in the home or community to an individual in performing Activities of Daily Living (ADL) tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided by:

1. A Certified Nursing Assistant which is employed under a State licensed home care/home health agency and meets such standards of education and training as are established by the State for the provision of these activities.
2. A Personal Care Attendant via Employer Authority under the Self Direction option.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

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

PREVENTIVE SERVICES:

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

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

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

Respite Services: Temporary caregiving services given to an individual unable to care for himself/herself that is furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care for the participant. Respite services will be recommended and approved by EOHHS, Office of Long Term Services and Supports.

Personal Care Services: Personal Care Services provide direct hands on support in the home or community to an individual in performing Activity of Daily Living (ADL) tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided to an individual by:

1. A Certified Nursing Assistant which is employed under a State licensed home care agency and meets such standards of education and training as are established by the State for the provision of these activities.

HABILITATIVE SERVICES:

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

Residential habilitation is individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision.

Payment is not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

Day habilitation is provision of regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the participant's person-centered plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered services and supports plan, such as physical, occupational, or speech therapy.

ATTACHMENT C - Assessment and Coordination Organization

Rhode Island Long-Term Services and Supports Assessment and Coordination Organization

Summary:

The Assessment and Coordination Organization is not an actual organization. It is, instead, the organization of several current disparate *processes* that individuals and families use when seeking long-term services and supports. Today, if an individual needs institutional or community-based long-term care services, information about those services and ways to access the services is available from many different sources. These sources include: *The Point*, 211, community agencies, discharge planners, etc. Despite the well-meaning efforts of these entities, the complexity of Rhode Island's long-term care system does not always ensure the information is consistent, valid, or current.

The first goal of the Assessment and Coordination Organization is to ensure that the information about Rhode Island's publicly funded long-term services and supports system provided by all sources is accurate and timely. In order to achieve this goal, the state will seek to enter into interagency agreements with each entity identified as a primary information source.

Different agreements will be developed to reflect the unique relationship each primary information source has with the publicly-funded long-term services and supports system. For example, the State's Aging and Disability Resource Center, *The Point*, was created for the sole purpose of providing information, referrals, and general assistance for seniors, adults with disabilities, and their caregivers. The interagency agreement with *The Point* will reflect that role and will differ from the agreement that the state might enter with community agencies who view information and referral as secondary to their primary missions. Entities such as physician practices will be included in this primary information source group to the extent it is reasonable. For example, primary care practices that participate in the Connect Care Choice program will be given training on the existing programs so that they may better serve their Connect Care Choice members who have long-term services and supports needs.

The interagency agreements will delineate the various ways the primary information source entity will receive information about the publicly funded long-term care systems and other health care programs, including electronic transmissions, written information, trainings, and workshops. The agreements will indicate ways to access state agency representatives if more information is needed. The agreements will also provide guidance on the second function of primary information source entities, appropriate referral of individuals to the next step.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

Appropriate referral is the second goal of the Assessment and Coordination Organization. The state will ensure those primary information sources can direct persons to the appropriate next step – whether that next step is assessment for long-term care services; counseling for enrollment into an acute care managed care program; or referral to a specific state agency for more information. In order to achieve this goal, the will develop a universal screening tool. This tool will be developed to capture information quickly that is necessary for the primary information source to determine the most appropriate placement and/or service referral.

Depending on the results of the initial screen, an individual may be referred to the following areas:

- Individuals determined to have a potential need for Medicaid funded long-term services and supports in a nursing facility or in the community will be referred to the Rhode Island Executive Office of Health and Human Services (EOHHS);
- Individuals determined to have a potential need for state-only funded long-term services and supports will be referred to the Rhode Island Department of Elderly Affairs (RI-DEA);
- Individuals determined to have a potential need for services for the developmentally disabled or mentally retarded will be referred to the Rhode Island Department of Mental Health, Retardation, and Hospitals (RI-MHRH);
- Individuals determined to have a potential need for long-term hospital services will be referred to Eleanor Slater Hospital, a state hospital that treats patients with acute and long term medical illnesses, as well as patients with psychiatric disorders;
- Individuals determined to have a potential need for behavioral health services for a child or for an adult will be referred to the Rhode Island Department of Children, Youth, and Families (RI-DCYF) or the RI-MHRH, respectively;
- Individuals who are seeking information for services other than long-term care will be referred to the appropriate place. For example, information on acute care managed care options is currently provided by the EOHHS Enrollment Hotline.

The assessment entities will be responsible for:

- Coordinating with the Medicaid eligibility staff;
- Conducting assessments;
- Determining levels of care;
- Developing service plans with the active involvement of individuals and their families;
- Developing funding levels associated with care plans;
- Conducting periodic reviews of service plans;
- Coordinating services with care management entities (Connect Care Choice; PACE; Rhody Health Partners);

Assessments and related functions are currently conducted by the state agencies (or their contracted entities) listed above. The development of care plans is one of the most important functions

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

conducted by these entities or their contractors. The Assessment and Coordination Organization will ensure that these care plans are developed with the active participation of individuals and families. Full consumer participation will require information about the cost of services, utilization, and quality. One of the goals of the Waiver will be to provide the individual and his/her family with health reports that will indicate the amount that has been spent on the individual's services. This information will allow an individual to make more-informed choices about where his/her service plan dollars should be spent. These health reports will be generated through the CHOICES MMIS Module.

The Assessment and Coordination Organization's third goal is to ensure improved and increased communication between these assessment entities. For example, if an individual assessed by RI-DHS for long-term community-based care is also found to have behavioral health needs, the individual's service plan will be developed in coordination with RI-MHRH. Communication between the assessment entities will occur through regular meetings and training sessions.

RI-DHS, in close coordination with the other EOHHS agencies, will provide the administrative functions of the Assessment and Coordination Organization. These functions include: ensuring that the primary information entities and the assessment entities coordinate functions and communicate amongst each other and with each other; establishing training sessions and workshops; regularly tracking utilization; and monitoring outcomes to ensure that the Assessment and Coordination Organization's goals are met. On-going monitoring will enable the state to conduct interdisciplinary high-cost case reviews that could ultimately result in improvements to the system.

Rhode Island Comprehensive Demonstration
Demonstration Approval Period: December 23, 2013 through December 31, 2018
Amended September 24, 2018

ATTACHMENT D - Level of Care Criteria

Long-term Care Level of Care Determination Process

Attached are: (1) A chart comparing the level of care determination process as determined by the section 1115a Comprehensive demonstration; and (2) A document describing the criteria for the highest level of care – with the waiver – developed by a workgroup that included members from the nursing home industry, consumer advocates, and health professionals. The state is in the process of developing similar criteria for the other two levels of care proposed in the Comprehensive demonstration.

| Level of Care Determination Process: With the Comprehensive Waiver | | |
|--|--|---|
| LTC Level of Care and Service Option Matrix | | |
| Highest Nursing Home Level of Care (Access to Nursing Facilities and all Community-based Services) | Highest Hospital Level of Care (Access to Hospital, Group Homes, Residential Treatment Centers and all Community-based Services) | Highest ICF/IDD Level of Care (Access to ICFMR, Group Homes and all Community-based Services) |
| High Nursing Home Level of Care (Access to Core and Preventive Community-based Services) | High Hospital Level of Care (Access to Core and Preventive Community-based Services) | High ICF/IDD Level of Care (Access to Core and Preventive Community-based Services) |
| Preventive Nursing Home Level of Care (Access to Preventive Community-based Services) | Preventive Hospital Level of Care (Access to Preventive Community-based Services) | Preventive ICF/IDD Level of Care (Access to Preventive Community-based Services) |

Rhode Island Comprehensive Demonstration
 Demonstration Approval Period: December 23, 2013 through December 31, 2018
 Amended September 24, 2018

Institutional Level of Care Determination Policy: Nursing Facility

Highest Need Group

An individual who meets any of the following eligibility criteria shall be eligible and enrolled in the Highest Needs group:

1. An individual who requires extensive assistance or total dependence with at least one of the following Activities of Daily

Living (ADL):

Toilet use

Bed mobility

Eating

Transferring

AND who requires *at least* limited assistance with any other ADL.

OR

2. An individual who lacks awareness of needs or has moderate impairment with decision-making skills AND one of the

following symptoms/conditions, which occurs frequently and is not easily altered:

Wandering

Verbally Aggressive Behavior

Resisting Care

Physically Aggressive Behavior

Behavioral Symptoms requiring extensive supervision

OR

3. An individual who has at least one of the following conditions or treatments that requires skilled nursing assessment,

monitoring, and care on a daily basis:

Stage 3 or 4 Skin Ulcers

Ventilator/Respirator

IV Medications

Naso-gastric Tube Feeding

End Stage Disease

Parenteral Feedings

2nd or 3rd Degree Burns

Suctioning

Gait evaluation and training

OR

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

4. An individual who has an unstable medical, behavioral, or psychiatric condition(s), or who has a chronic or recurring

condition that requires skilled nursing assessment, monitoring, and care on a daily basis related to, but not limited to, at

least one of the following:

| | |
|--|----------------------|
| Dehydration | Internal Bleeding |
| Aphasia | Transfusions |
| Vomiting | Wound Care |
| Quadriplegia | Aspirations |
| Chemotherapy | Oxygen |
| Septicemia | Pneumonia |
| Cerebral Palsy | Dialysis |
| Respiratory Therapy | Multiple Sclerosis |
| Open Lesions | Tracheotomy |
| Radiation Therapy | Gastric Tube Feeding |
| Behavioral or Psychiatric conditions that prevent recovery | |

OR

5.

An individual who does not meet at least one of the above criteria may be enrolled in the Highest Needs Group when the

Executive Office of Health and Human Services determines that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual's health and safety. **Definitions*

- Extensive Assistance (Talk, Touch, and Lift): Individual performs part of the activity, but caregiver provides physical assistance to lift, move, or shift individual.
- Total Dependence (All Action by Caregiver): Individual does not participate in any part of the activity
- Limited Assistance (Talk and Touch): Individual highly involved in the activity, but received physical guided assistance and no lifting of any part of the individual.

High Need Group

An individual who meets any of the following eligibility criteria shall be eligible and enrolled in the High Needs group:

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

1. An individual who requires at least limited assistance on a daily basis with at least two of the following ADLs:

| | |
|--------------------------|------------|
| Bathing/Personal Hygiene | Dressing |
| Eating | Toilet Use |
| Walking/Transfers | |

2. An individual who requires skilled teaching on a daily basis to regain control of, or function with, at least one of the following:

| | |
|-----------------|---------------------------|
| Gait training | Speech |
| Range of motion | Bowel or bladder training |

3. An individual who has impaired decision-making skills that requires constant or frequent direction to perform at least one of the following:

| | |
|--------------|------------------|
| Bathing | Dressing |
| Eating | Toilet Use |
| Transferring | Personal hygiene |

4. An individual who exhibits a need for a structured therapeutic environment, supportive interventions, and/or medical management to maintain health and safety.

Preventive Need Group

An individual who meets the preventive service criteria shall be eligible for enrollment in the preventive needs group. Preventive care services are designed to promote and preserve health and safety or to alleviate symptoms to address functional limitations. Preventive services may avert or avoid institutionalization. An individual in need of the following services, and who can demonstrate that these services will improve or maintain abilities and/or prevent the need for more intensive services, will be enrolled in the preventive need group.

1. Homemaker Services: General household tasks including basic home and household assistance for a health condition or to address functional limitations. The services include meal preparation, essential shopping, laundry, and cleaning for an individual without a social support system able to perform these services for him/her. These services may be performed and covered on a short term basis after an individual is discharged from an institution and is not capable of performing these activities himself/herself.

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

2. **Minor Environmental Modifications:** Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers) and standing poles to improve home accessibility adaption, health, or safety.
3. **Physical Therapy Evaluation and Services:** Physical therapy evaluation for home accessibility appliances or devices by an individual with a state-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.
4. **Respite Services:** Temporary caregiving services given to an individual unable to care for himself/herself that is furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care for the participant. Respite services will be recommended and approved by EOHHS, Office of Long Term Services and Supports.
5. **Personal Care Services:** Personal Care Services provide direct hands on support in the home or community to an individual in performing Activity of Daily Living (ADL) tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided to an individual by:
 - a. A Certified Nursing Assistant which is employed under a State licensed home care agency and meets such standards of education and training as are established by the State for the provision of these activities.

Assessments and Reassessments

1. An individual enrolled in the High Needs group who, at reassessment or a change in status, meets any of the Highest Needs eligibility criteria shall be enrolled in the Highest Needs group.
2. **Re-Evaluation of Needs for an individual in the Highest Needs Group:**

When the Department of Human Services determines that an individual is admitted to a nursing facility or meets the Highest Needs Group level of care, the Nurse Consultant designates those instances in which the individual's medical information indicates the possibility of significant functional and/or medical improvement within two (2) months.

Notification is sent to the individual, to his/her authorized representative, and to the Nursing Facility that a Nursing Facility level of care has been approved, but functional and medical status will be reviewed again in thirty (30) to sixty (60) days. At the time of the review, the Nurse Consultant must first confirm that the individual remains a resident of the nursing facility. For an individual remaining in a nursing facility, the Nurse Consultant reviews the most recent Minimum Data Set and requests any additional information necessary to make one of the following determinations:

a. The individual no longer meets a Highest Needs Group level of care. In this instance, the Long Term Care Office is notified of the Highest Needs Group Level of Care denial, and the Long Term Care Unit sends a discontinuance notice to the individual, to his/her authorized representative if one has been designated, and to the nursing facility. Prior to being sent a discontinuance notice, the individual will be evaluated to determine if the individual qualifies for the High Needs group.

b. The individual continues to meet the appropriate level of care, and no action is required.

3. An individual residing in the community who is in the Highest and High groups will have, at a minimum, an annual assessment.

ATTACHMENT E - Quarterly Progress Report Template and Instructions

As stated in Special Terms and Conditions paragraph 114, the state must submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report template is intended as a framework, and can be modified when CMS and the state agree to the modification. A complete quarterly progress report must include the budget neutrality monitoring workbook.

I. Narrative Report Format

Title Line One - _____ (*Name of Individual State Program*)

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: year # and dates

II. Introduction

Describe the goal of the demonstration, what service it provides, and key dates of approval/operation. (*This should be the same for each report.*)

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

III. Enrollment Information

Complete the following table that outlines all enrollment activity under the demonstration. Indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by placing “0” in the appropriate cell.

***Note:** Enrollment counts should be participant counts, not participant months.*

| Population Groups (as hard coded in the CMS-64) | Number of Current Enrollees (to date) | Number of Voluntary Disenrollments in Current Quarter* | Number of Involuntary Disenrollments in Current Quarter** |
|--|--|--|--|
| Budget Population 1: ABD no TPL | | | |
| Budget Population 2: ABD TPL | | | |
| Budget Population 3: Rite Care | | | |
| Budget Population 4: CSHCN | | | |
| Budget Population 5: EFP | | | |
| Budget Population 6: Pregnant Expansion | | | |
| Budget Population 7: CHIP Children | | | |
| Budget Population 8: Substitute care | | | |
| Budget Population 9: CSHCN Alt | | | |
| Budget Population 10: Elders 65 and over | | | |
| Budget Population 11: 217-like group | | | |
| Budget Population 12: 217-like group | | | |
| Budget Population 13: 217-like group | | | |
| Budget Population 14: BCCTP | | | |
| Budget Population 15: AD Risk for LTC | | | |
| Budget Population 16: Adult Mental Unins | | | |
| Budget Population 17: Youth Risk Medic | | | |
| Budget Population 18: HIV | | | |
| Budget Population 19: AD Non-working | | | |
| Budget Population 20: Alzheimer adults | | | |
| Budget Population 21: Beckett aged out | | | |

*Voluntary Disenrollments:

Cumulative Number of Voluntary Disenrollments Within Current Demonstration Year:

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

Reasons for Voluntary Disenrollments.

****Involuntary Disenrollments:**

Cumulative Number of Involuntary Disenrollments Within Current Demonstration Year:

Reasons for Involuntary Disenrollments:

If the demonstration design includes a self-direction component, complete the following two sections:

IV. “New”-to-“Continuing” Ratio

Report the ratio of new-to-continuing Medicaid personal care service clients at the close of the quarter.

V. Special Purchases

Identify special purchases approved during this quarter (by category or by type).

Examples of “special purchases” have been provided below.

| # of Units/ Items | Item or Service | 150. of Item/Service Description (if not self-explanatory) | Total Cost |
|-------------------------|-----------------|---|-------------------|
| 10 | Microwaves | | \$1,000.89 |
| 1 | Water Therapy | Aqua massage therapy that will assist individual with motor function. | \$369.00 |
| CUMULATIVE TOTAL | | | \$1,369.89 |

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter.

VIII. Financial/Budget Neutrality Developments/Allotment Neutrality Developments/Issues

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

Identify all significant developments/issues/problems with financial accounting, budget neutrality, CMS-64 reporting for the current quarter, and, if appropriate, allotment neutrality and CMS-21 reporting for the current quarter. Identify the State's actions to address these issues.

IX. Consumer Issues

Summarize the types of complaints or problems enrollees identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

X. Marketplace Subsidy Program Participation

Complete the following table that displays enrollment and cost information pertaining to the Marketplace Subsidy Program. Include a summary and explanation of any trends discovered.

| <u>Month</u> | <u>Number of Marketplace Subsidy Program Enrollees</u> | <u>Change in Marketplace Subsidy Program Enrollment from Prior Month</u> | <u>Average Size of Marketplace Subsidy Received by Enrollee</u> | <u>Projected Costs</u> | <u>Actual Costs</u> |
|------------------|--|--|---|------------------------|---------------------|
| <u>January</u> | | | | | |
| <u>February</u> | | | | | |
| <u>March</u> | | | | | |
| <u>April</u> | | | | | |
| <u>May</u> | | | | | |
| <u>June</u> | | | | | |
| <u>July</u> | | | | | |
| <u>August</u> | | | | | |
| <u>September</u> | | | | | |
| <u>October</u> | | | | | |
| <u>November</u> | | | | | |
| <u>December</u> | | | | | |

XI. Accountable Entities Activity

XII. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in current quarter.

XIII. Enclosures/Attachments

Identify by title any attachments along with a brief description of the information contained in the document.

XIV. State Contact(s)

Identify individuals by name, title, telephone, fax, and address so that CMS may contact individuals directly with any questions.

XV. Date Submitted to CMS

Enter the date submitted to CMS in the following format: (mm/dd/yyyy).

The state may add additional program headings as applicable.

ATTACHMENT F – HCBS Evidentiary Review Guidance

HCBS Quality Review Worksheet

| I. Level of Care (LOC) Determination | |
|--|--|
| <i>The state demonstrates that it implements the processes and instrument(s) in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's LOC consistent with care provided in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disability.</i> | |
| Sub Assurances | CMS Expectations |
| An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future. | State submits evidence that it has reviewed applicant files to verify that individual level of care evaluations are conducted. |
| The level of care of enrolled participants is reevaluated at least annually or as specified in its approved waiver. | State must conduct at least annually reevaluations of level of care or as specified in the approved waiver. |
| The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care. | State submits that it regularly reviews participant files to verify that the instrument described in approved waive is used in all level of care redeterminations, the person(s) who implement level of care determinations are those specified in approved waiver, and the process/instruments are applied appropriately. |

| II. Service Plans | |
|---|--|
| <i>The state demonstrates it has designed and implemented an effective system of reviewing the adequacy of service plans for waiver participants.</i> | |
| Sub Assurances | CMS Expectations |
| Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means. | State demonstrates that service plans are reviewed at least annually to assure that all of participant needs are addressed and preferences considered. |
| The state monitors service plan development in accordance with its policies and procedures. | State must develop service plans according to policies and procedures. |
| Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs. | State submits evidence of its monitoring process for service plan update/revision including service plan updates taken when service plans were not updated/revised according to policies and procedures. |
| Services are delivered in accordance with the service plan, including the type, scope, amount, and frequency specified in the service plan. | State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented. |
| Participants are afforded choice: (1) Between waiver services and institutional care; and, (2) Between/among waiver services and providers. | State must still offer choice and a mechanism for ensuring the services identified in the service plan are implemented. |

| III. Qualified Providers | |
|--|--|
| <i>The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.</i> | |
| Sub Assurances | CMS Expectations |
| The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver service. | State provides documentation of periodic review by licensing/certification entity. |

| | |
|---|--|
| The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements. | State provides documentation that non-licensed/non-certified providers are monitored on a periodic basis sufficient to provide protections to waiver participants. |
| The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver. | State provides documentation of monitoring of training and actions it has taken when providers have not met requirements (e.g., technical assistance, training) |

| IV. Health and Welfare | |
|--|--|
| <i>The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.</i> | |
| Sub Assurances | CMS Expectations |
| The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible. | State must establish a critical incident management system, which investigates, substantiates, and provides recommended actions to protect health and welfare |
| The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed. | State must develop policies and procedures that address the use or prohibition of restrictive interventions. |
| The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver. | State submits evidence that on an ongoing basis, it monitors services providers to ensure overall healthcare standards are as stated in the approved waiver. |
| The state, on an ongoing basis, identifies, address, and seeks to prevent the occurrence of abuse, neglect, exploitation and unexplained death. | State demonstrates that, on an ongoing basis, abuse, neglect, exploitation and unexplained death are identified, appropriate actions have been taken when the health or welfare of a participant has not been safeguarded, and an analysis is conducted of abuse, neglect and exploitation trends and unexplained death trends and strategies it has implemented for prevention. |

| V. Administrative Authority | |
|--|--|
| <i>The state demonstrates that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application.</i> | |
| Sub Assurances | CMS Expectations |
| The state Medicaid agency retains the ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities. | State submits evidence of its monitoring of all delegated functions, and implementation of policies/procedures related to its administrative authority over the waiver program, including: memoranda of agreements, description of roles and responsibilities relative to program operations, monitoring, and remediation or system improvements instituted when problems are identified in the operation of the waiver program. |

| VI. Financial Accountability | |
|--|---|
| <i>The state demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.</i> | |
| Sub Assurance | CMS Expectations |
| State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. | <ul style="list-style-type: none"> • State submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in the approved waiver. • State submits results of its review of waiver participant claims to verify that they are coded and paid in accordance with the waiver reimbursement methodology. • State demonstrates that interviews with state staff and providers are periodically conducted to verify that any identified financial irregularities are addressed. • State demonstrates that site visits are conducted with providers to verify that they maintain financial records according to provider agreement/contracts. |

The state may submit summary reports for each HCBS sub assurance outline above based on a significant sample of any single or combined method or source of evidence as follows:

- Record reviews, on-site
- Record reviews, off-site
- Training verification records
- On-site observations, interviews, monitoring
- Analyzed collected data (including surveys, focus group, interviews, etc.)
- Trends, remediation actions proposed/taken
- Provider performance monitoring
- Operating agency performance monitoring
- Staff observation/opinion
- Participant/family observation/opinion
- Critical events and incident reports
- Mortality reviews
- Program logs

Rhode Island Comprehensive Demonstration

Demonstration Approval Period: December 23, 2013 through December 31, 2018

Amended September 24, 2018

- Medication administration data reports, logs
- Financial records (including expenditures)
- Financial audits
- Meeting minutes
- Presentation of policies or procedures
- Reports to state Medicaid agency or delegated administrative functions
- Other

Attachment G: Reserved for Comprehensive Quality Strategy
Attachment G

Attachment H: Reserved for Description of Healthy Behaviors Incentives Program

Attachment I: Reserved for Evaluation Plan

Attachment J: Hospital and Nursing Home Facilities Measures

Nursing Home Measures

| Domain | Measure | Num | Den | Time Period | Data Source |
|------------------|---|--|--|--|---------------------------------|
| Utilization | All-cause, risk adjusted re-hospitalization measure. It provides the rate at which all patients (regardless of payer status or diagnosis) who enter skilled nursing facilities (SNFs) from acute hospitals and are subsequently re-hospitalized during their SNF stay, within 30 days from their admission to the SNF. Measure Steward AHCA* http://www.qualityforum.org/QPS/2375 | Number of patients sent back to any acute care hospital (excluding emergency room only visits) during their SNF stay within 30 days from a SNF admission, as indicated on the MDS 3.0 discharge assessment during the 12 month measurement period. | Total number of all admissions regardless of payer status and diagnosis, with an MDS 3.0 admission assessment to a SNF from an acute hospital during the target rolling 12 month period. | Baseline: 10/1/14 - 12/31/14 Measurement period: 10/1/15 - 12/31/15 | MDS Data |
| HIT/Structural | The percentage of Medicaid patients enrolled in Currentcare. Note: Providers should also indicate the strategies they have employed to increase Currentcare enrollment. | Number of Currentcare enrolled Medicaid beneficiaries | Total number of Medicaid beneficiaries | Baseline: 7/1/14-6/30/15 Measurement Period: 7/1/15-6/30/16 | Enrollment Data |
| | | | | | |
| Clinical Quality | The percentage of long-stay residents who are receiving antipsychotic drugs in the target period. | Number of long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received. | Total number of long-stay residents with a selected target assessment, except those with exclusions. | Baseline: 4/1/14-12/31/14 Measurement period: 4/1/15-12/31/15 | MDS Data reported on NH Compare |

Hospital Measures

| Domain | Measure | Numerator | Denominator | Time Period | Data Source |
|------------------------|---|---|---|---|----------------------|
| Utilization | <p>30 day hospital readmissions (Medical): The measure estimates a hospital-level risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge.*</p> <p>Measure Steward: CMS, NQF 1789.Hospital Inpatient Quality Reporting: http://www.qualityforum.org/QPS/1789</p> | Number of inpatient admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from an eligible index admission. | Total number of Medicaid members \geq 18 years of age | <p>Baseline: 7/1/14-6/30/15</p> <p>Measurement period: 7/1/15-3/30/16</p> | Encounter Data |
| | <p>30 day hospital readmissions (Behavioral Health) For members 18 years and older, the % of acute inpatient psychiatric stays during the measurement year that were followed by an acute readmission for a psychiatric diagnosis within 30 days.</p> <p>Measure Steward: State of Washington DSHS*</p> | Number of re-admissions w/in 30 days of discharge from inpatient psychiatric care | Total number of Medicaid members \geq 18 years of age | <p>Baseline: 7/1/14-6/30/15</p> <p>Measurement period: 7/1/15-3/30/16</p> | Encounter Data |
| | | | | | |
| Value Based Purchasing | <p>Overall percentage of revenue derived from APM payment in total and stratified by revenue based from the following APM arrangements:</p> <ul style="list-style-type: none"> Pay for Performance Bundled Capitation (Full Risk/Upside Only) Capitation (Full Risk/Upside/Downside) Other | The total amount of payments from payers made to the provider on behalf of patients enrolled in any approved Alternative Payment Arrangement, as defined by OHIC and including Accountable Entities, Accountable Care Organizations, IHH, PCMH, other total cost of care arrangements, and other approved APMs. | Total payments received from all payers | <p>Baseline: 7/1/14-6/30/15</p> <p>Measurement period: 7/1/15-7/30/16</p> | Provider Self Report |

| | | | | | |
|-------------------------|---|---|---|--|---|
| HIT/Structural | Percentage of Medicaid patients enrolled in CurrentCare. Note: Providers should also indicate the strategies they have employed to increase CurrentCare enrollment. | Number of Currentcare enrolled Medicaid beneficiaries | Total number of Medicaid beneficiaries | Baseline: 7/1/14-6/30/15 Measureme nt period: 7/1/15-7/30/16 | Currentca re Enrollme nt Data |
| | | | | | |
| Clinical Quality | Reduction in Catheter Associated Urinary Tract Infection (CAUTI) infection rate* | Number of observed CAUTI infections. | Total number of expected CAUTI infections. | Baseline: 1/1/13 - 12/31/13 Measureme nt period: 1/1/14 - 12/31/14 | CMS Hospital Inpatient Reporting Data |
| | Reduction in C-Diff infection rate* | Number of observed C-diff infections. | Total number of expected C-diff infections. | Baseline: 1/1/13 - 12/31/13 Measureme nt period: 1/1/14 - 12/31/14 | CMS Hospital Inpatient Reporting Data |

Attachment K: Accountable Entities Certification Standards

Rhode Island Medicaid Accountable Entity Program

Attachment L 1: Accountable Entity Total Cost of Care Requirements

Rhode Island Executive Office of Health and Human Services
September 29, 2017

Table of Contents

| | |
|--|-----------|
| A. TCOC Definition | 3 |
| B. TCOC Methodology Goals | 3 |
| C. General Requirements for Program Participation | 4 |
| 1. Minimum Membership and Population Size | |
| 2. State/MCO Capitation Arrangement | |
| 3. Exclusivity of Approved TCOC Methodologies | |
| 4. Other Approved Alternative Payment Methodologies for LTSS Providers | |
| 5. Attribution | |
| D. TCOC Methodology: Required Elements for Comprehensive AEs | 5 |
| 1. Defining a Historical Base | |
| 2. Required Adjustments to the Historical Base | |
| 3. TCOC Expenditure Target for the Performance Period | |
| 4. Actual Expenditures for the Performance Period | |
| 5. Shared Savings/(Loss) Pool Calculations | |
| 6. AE Share of Savings/(Loss) Pool | |
| 7. Required Progression to Risk Based Arrangements | |
| E. TCOC Methodology: Required Elements for Specialized LTSS AEs | 11 |
| 1. Defining a Historical Base | |
| 2. Required Adjustments to the Historical Base | |
| 3. TCOC Expenditure Target for the Performance Period | |
| 4. Actual Expenditures for the Performance Period | |
| 5. Shared Savings/(Loss) Pool Calculations | |
| 6. AE Share of Savings/(Loss) Pool | |
| 7. Required Progression to Risk Based Arrangements | |
| F. TCOC Development and Approval Process | 17 |
| G. Other APMs for Specialized LTSS AEs | 18 |
| H. Comprehensive AE TCOC Methodology Example | 20 |
| I. Specialized LTSS AE TCOC Methodology Example | 22 |
| Attachments | |
| • Attachment A | |

Services Included in Specialized LTSS AE TCOC Analyses

- **Attachment B**
Quality Framework and Methodology for Comprehensive and Specialized LTSS Accountable Entities

A. TCOC Definition

The total cost of care (TCOC) calculation is a fundamental element in any shared savings and/or risk arrangement. Most fundamentally, it includes a historical baseline or benchmark cost of care specifically tied to an Accountable Entity's (AE) attributed population projected forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

Effective TCOC methodologies provide an incentive for AEs to invest in care management and other appropriate services to address the needs of their attributed populations and reduce duplication of services. For populations with long-term care needs, effective TCOC methodologies also provide incentives for AEs to help beneficiaries live successfully in the community and reduce use of institutional services. In doing so, AEs will be able to improve outcomes, lower overall healthcare costs, and be able to earn savings. Shared savings distributions must be based on well-defined quality and outcomes metrics.

B. TCOC Methodology Goals

These TCOC guidelines have been designed to support **Meaningful Performance Measurement**, thereby creating financial incentives to reduce costs and improve quality. In order to accomplish meaningful performance measurement, this methodology must incorporate the following:

- **Provide opportunity for a sustainable business model**
Create ongoing opportunity for effective AEs by: (1) recognizing efficient historical performers; (2) allowing for shared savings to be retained for system investment; (3) creating greater financial incentives for being inside the AE program than for being outside; (4) identifying clinical pathways for complex co-occurring chronic conditions that are prevalent among Medicaid high utilizers; (5) addressing social determinants (e.g., housing, food security, access to non-medical transportation) that impact health outcomes and costs; and (6) implementing effective interventions to help elders and adults with disabilities remain in the community.
- **Be fiscally responsible for all participating parties**
Adequately protect the solvency of the AEs and managed care organizations (MCOs) and the financial interests of the RI Medicaid Program.
- **Specifically recognize and address the challenge of small populations**
Implement mitigation strategies to minimize the impact of small numbers, given the state's small size and particularly related to LTSS.
- **Incorporate quality metrics related to increased access and improved member outcomes**
Have reporting mechanisms for MCOs and AEs that allow for timely data exchange and performance improvement to ensure access and quality.
- **Define and establish a progression toward meaningful AE risk**

- **Establish consistent core components of the TCOC methodology while still allowing some innovation and flexibility**

Balance these competing goals. Allow for some variation in TCOC methodology within uniform state guidelines/criteria, with recognition of the importance of alignment in the methodology for the managed care and fee-for-service populations attributed to specialized LTSS AEs.

C. General Requirements for Program Participants

1.

1. Minimum Membership and Population Size

For comprehensive AEs, MCOs may utilize TCOC-based payment models only with AEs which have at least 5,000 attributed Medicaid members, across all MCOs. For specialized LTSS AEs, there must be at least 500 attributed lives in Medicaid managed care and/or Medicaid fee-for-service.

2. State/MCO Capitation Arrangement

The MCO retains the base contract with the State; the MCO medical capitation will be adjusted for savings/risk associated with the program as described in the State/MCO contract. This does not preclude MCOs from creating value-based purchasing arrangements with non-AE providers; however, those contracts would still be subject to the State gain-share and would not be included in the State's assessment of the MCO's value-based payment performance standards related to AEs.

3. Exclusivity of Approved TCOC Methodologies

MCO TCOC arrangements shall supersede and be exclusive of any other TCOC-related shared savings arrangements with an AE or any of its constituent providers for Medicaid members.

4. Other Approved Alternative Payment Methodologies for LTSS Providers

The MCO and Medicaid fee-for-service may also implement other approved alternative payment methodologies (APMs) (as described in Section G), in addition to TCOC arrangements, for providers in specialized LTSS AEs. Participation in those APMs is voluntary for providers.

5. Attribution

AE specific historic base data must be based on the AE's attributed lives for a given period, in accordance with EOHHS defined attribution requirements, as defined separately. TCOC performance period data must account for and be aligned with the list of attributed members. MCOs are required to generate on a monthly basis, as described in the attribution requirements.

D. TCOC Methodology: Required Elements for Comprehensive AEs

MCO TCOC arrangements with comprehensive AEs must meet the following requirements, listed here and described in more detail below:

1. Defining a Historical Base
2. Required Adjustments to the Historical Base
3. TCOC Expenditure Target for the Performance Period
4. Actual Expenditures for the Performance Period
5. Shared Savings/(Loss) Pool Calculations
6. AE Share of Shared Savings/(Loss) Pool
7. Required Progression to Risk Based Arrangements

1. Defining a Historical Base

a. AE-Specific Historical Cost Data

The TCOC historical base shall include three years of AE-specific historical cost data with equal weighting applied to each year. MCOs are strongly encouraged to use three years of historic data in creating the benchmark to stabilize the historic base; at a minimum, all existing AE experience must be utilized.

b. Covered Services

TCOC methodologies shall include all costs associated with covered services that are included in EOHHS's contract with MCOs for the performance year, with the following clarifications/exceptions. Any further adjustments to covered services outside of those listed below must be requested in writing and pre-approved by EOHHS prior to MCO-AE contract execution for the affected contractual performance year:

- I. Exclude services currently covered under stop-loss provisions between EOHHS and the MCO, as outlined below:
 - Long-term care in an intermediate or skilled facility in excess of 30 days.
 - Costs associated with the transplant of a bodily organ. Includes costs incurred from the date of admission through the date of discharge associated with the specific hospital stay in which an organ is implanted. The AE TCOC calculation will include all costs up to the transplant of a bodily organ.
 - Early Intervention Services in excess of \$5,000 for an individual.
 - Hepatitis C Pharmacy Costs: Costs in excess of the per member per month level as set forth in the *Provisions for Stop Loss Claiming for Pharmacy Expenditure in Treatment of Enrollees with Hepatitis C*.
- II. Exclude HSTP performance incentive payments and CTC payments.
- III. Include and define any other infrastructure payments made by MCOs to AEs and AE-affiliated providers.

c. Mitigation of Impact of Outliers: Claims threshold for high cost claims

TCOC expenditure data shall be adjusted to exclude costs in excess of \$100,000 per member per year. However, TCOC expenditures must include 10% of any annualized spending per member above the truncation threshold.

d. Adjusting for a Changing Risk Profile

To account for possible changes in the risk profile of an AE's attributed patient population over the historical base years, the MCO shall employ one of the following two risk adjustment methodologies:

- **Risk Adjustment Software**

MCOs may apply a clinical risk adjustment software. Under such an approach, risk calculations and any adjustments shall be applied at the total population and not the EOHHS rate cell level. The TCOC methodology must describe the MCO's risk-adjustment method including underlying software parameters set by the MCO. Such information shall also be disclosed to contracting AEs.

- **Rate Cell Calculations**

MCOs may use the population mix by rate cell, for each period, to adjust for changes in this population mix over time.

Note that if an MCO chooses to utilize a risk adjustment software, the MCO must provide a detailed description of the specific software/methodology applied, including the underlying parameters set by the MCO. Note that this is an interim solution, as the state intends to implement a standardized risk adjustment methodology over the course of this program. Should the MCO wish to further adjust for a changing risk profile using clinical and social risk factor data exogenous to the risk adjustment methodologies described above, it may do so after review and approval by EOHHS.

e. Historical Base with Required Cost Trend Assumptions

When projecting (or trending) historical costs forward into the performance year, TCOC methodologies shall appropriately account for trends in the medical component of capitation rates being paid to MCOs by EOHHS. Unless otherwise approved by EOHHS, trends assigned to TCOC baselines shall not exceed the final cumulative trends to the medical portion of rates contained in the EOHHS data books by cap cell. The trends may be applied by the MCO to the AE in aggregate based on either the AE's or the MCO's member mix.

2. Required Adjustments to the Historical Base

In order to prospectively establish an AE's TCOC Expenditure Target, the MCO must apply the following adjustments to the historical base. Note that no additional adjustments are allowed without prior approval from EOHHS.

a. Adjustment for Prior Year Savings

The TCOC Expenditure Target must include an upward adjustment equal to an AE's share of prior year savings, after adjustment for quality performance, so that AEs have an opportunity to retain a portion of generated savings year over year. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target.

b. Adjustment for Historically Low-Cost AEs

Should any AE have three years of historical cost data demonstrating that risk-adjusted per capita spending for the AE's historically attributed patient population for TCOC covered services was significantly below the MCO average (statistically significant at $p \leq .05$), the MCO may adjust that AE's TCOC Expenditure Target upward by up to the percentage by which the TCOC fell below MCO average spending for the assessed historical time period. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target. This adjustment shall not be applied to entities with a historically attributed patient population for TCOC covered services that was significantly above the MCO average.

3. TCOC Expenditure Target for the Performance Period

Once an AE-specific adjusted historical base is established, this base must be trended forward into the performance period to create an AE-specific TCOC Expenditure Target.

TCOC methodologies shall be based on a performance time period of 12 months aligned with the state fiscal year. Initial contractual performance time periods may extend longer than 12 months if necessary.

a. Required Cost Trend Assumptions

The adjusted historical base must be cost trended to the performance year according to the cost trend assumptions described in Section D.1.e of this document.

b. Final Target Adjusted for Changes in the Attributed Population's Risk Profile

The MCO must apply a risk adjustment methodology to assess any changes in an attributed population's risk profile from the risk-adjusted historical base to the contractual performance period. This methodology must be consistent with the risk adjustment methodology used in developing the adjusted historical base as described in Section D.1.d of this document.

4. Actual Expenditures for the Performance Period

a. Calculate Actual Expenditures Consistent with the Historical Base Methodology

Actual Expenditures for the Performance Period must be calculated consistent with the historical base methodology as described in Sections D.1.b and D.1.c of this document.

5. Shared Savings/(Loss) Pool Calculations

The Shared Savings/(Loss) Pool shall be calculated as the difference between Actual Expenditures (Section D.4) and TCOC Expenditure Target (Section D.3), after the following adjustments:

a. Small Sample Size Adjustment for Random Variation

TCOC methodologies shall account for statistical uncertainty in performance measurement due to the effect of random variation in utilization and spending in small populations. MCOs shall address the impact of random variation on cost savings results through the application of a shared savings adjustment factor, defined by performance year AE attributed population size (calculated as attributed member months divided by 12).

The shared savings adjustment factor adjusts the AE's shared savings/(loss) pool proportionately by the probability of true savings (1 minus the probability of achieving shared savings as a result of chance). The proportion of savings for which an AE is eligible shall be adjusted along a sliding scale by AE size, based on the parameters below. AEs with fewer than 5,000 attributed members with an MCO shall be classified as Small AEs.

Shared Savings/Loss Adjustment Factor Parameters

| Shared Savings/Loss Adjustment Factor Parameters by AE Size and Savings Rate | | | | Probability of Achieving Shared Savings/Loss as a Result of Chance* | | | |
|---|-----------------------|---------------------------------|-----------------------|--|------------------|-------------------|-------------------|
| Savings % | Small AE (5-9,999) | Medium AE (10- 19,999) | Large AE (20,000+) | Savings % | 5,000 members | 10,000 members | 20,000 members |
| 1% | 73% | 79% | 89% | 1% | 27% | 21% | 11% |
| 2% | 82% | 92% | 97% | 2% | 18% | 8% | 3% |
| 3% | 91% | 97% | 99% | 3% | 9% | 3% | 1% |
| 4% | 95% | 99% | 100% | 4% | 5% | 1% | 0% |
| 5% | 98% | 100% | 100% | 5% | 2% | 0% | 0% |
| 6% | 99% | 100% | 100% | 6% | 1% | 0% | 0% |

Source: Weissman J, Bailit MH, D'Andrea G, Rosenthal MB. "The Design And Application Of Shared Savings Programs: Lessons From Early Adopters," *Health Affairs*, September 2012

b. Impact of Quality and Outcomes

The Shared Savings/(Loss) Pool shall be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. An Overall Quality Score will be generated for each AE, according to the methodology detailed in Attachment B: Quality Framework and Methodology for Comprehensive and Specialized LTSS Accountable Entities. The Shared Savings/(Loss) Pool must be multiplied by the Overall Quality Score.

c. Maximum Allowable Shared Savings/(Loss) Pool

In any given performance year, the Shared Savings Pool must not exceed 10% of the AE's contract revenue. In instances where the AE is responsible for downside risk, the Shared Loss Pool must not exceed 5% of the AE's contract revenue.

6. AE Share of Savings/(Loss) Pool

In Year 1, AEs may be eligible to retain up to 40% of the Shared Savings Pool, as defined in Section D.5 above. AEs assuming downside risk may be eligible for up to 60% of the Shared Savings Pool, and may be responsible for up to 60% of the Shared Loss Pool.

| AE Shared Savings Model | AE Share of Savings | Maximum Allowable Shared Savings Pool | Maximum Allowable Shared Loss Pool | AE Share of Losses |
|--|---------------------------|---------------------------------------|------------------------------------|------------------------|
| Option 1: Shared savings only | Up to 40% of Savings Pool | 10% of AE contract revenue | NA | NA |
| Option 2: Shared savings + risk | Up to 60% of Savings Pool | 10% of AE contract revenue | 5% of AE contract revenue | Up to 60% of Loss Pool |

7. Required Progression to Risk Based Arrangements

Qualified TCOC-based contractual arrangements (or “Certified AEs”) must demonstrate a progression of risk to include meaningful downside shared risk within three years of AE program participation. After five years, development and implementation funding will end, and AEs will be sustained going forward based on their successful performance and associated financial rewards in accordance with their MCO contract(s).

EOHHS has defined “meaningful risk” based on learnings from other states, OHIC requirements and federal MACRA rules. Marginal risk and loss caps are defined with a range, EOHHS anticipates that smaller organizations will fall on the lower end of that range. The required progression of increasing risk for all comprehensive AEs is as follows:

| | Marginal Risk <i>AE Share of Losses</i> | Loss Cap <i>Maximum Shared Loss Pool</i> |
|-------------------|--|---|
| <i>Definition</i> | <i>The percentage of any Shared Loss Pool for which the AE is financially at risk.</i> | <i>The maximum percentage of the AE’s contract revenue for which the AE is financially at risk.</i> |
| Year 1 | 0 | NA |
| Year 2 | 0 | NA |
| Year 3 | 15 - 30% of any Shared Loss Pool | At least 2% No more than 10% |
| Year 4 | 30 - 50% of any Shared Loss Pool | At least 2% No more than 10% |
| Year 5 | 50 - 60% of any Shared Loss Pool | At least 2% No more than 10% |

It is EOHHS’s intent to align risk requirements with the standards established by the Office of the Health Insurance Commissioner (OHIC) to the extent possible. Alternatives for larger organizations or entities that include a hospital may be considered in the future.

In the event of a shared risk arrangement with an AE, it is necessary to ensure that the AE has the capacity to pay for its share of any losses. To accomplish this the MCO shall utilize a withhold to ensure that funds are available for financial settlement with the AE in the event that medical expenses exceed the total cost of care projection for the performance period. At a minimum, the withhold must capture 75 percent of the maximum shared loss pool. MCO's final settlement with the AE with regard to a withhold is based on actual experience in relation to the TCOC calculation.

Should an MCO and AE wish to share risk on a more accelerated schedule than that outlined above, the MCO and AE shall submit written documentation to EOHHS, including:

- the draft contractual financial terms between the parties;
- a statement of why the AE is qualified to assume greater risk than that outlined above, including its infrastructure to manage clinical risk, an established record of meeting quality metrics, and the likelihood that the AE will meet the quality thresholds established by EOHHS and the MCO; and
- documentation of secured funds necessary to meet the maximum financial obligation that the AE could potentially incur under the terms of the proposed agreement.

EOHHS together with state partners (e.g. DBR and OHIC), will review the aforementioned information, and decide as to whether the arrangement may proceed.

Additionally, if an AE enters into an arrangement that provides for shared losses with a total potential risk that equals or exceeds 10% of expected expenditures, the AE must meet all the financial reserve and risk-based capital requirements required of an MCO, with oversight by the Department of Business Regulation.¹ EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three months of claims.²

¹ As specified in the standards for minimum risk-based capital (RBC) requirements for health organizations in Chapter 27-4.7 of the RI general statute. <http://webserver.rilin.state.ri.us/Statutes/Title27/27-4.7/INDEX.HTM>

² Note that CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. For ease of reference links to relevant State Medicaid Director Letters are provided: www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf; www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf. Links for the Medicare Shared Savings Program final rule and a CMS Factsheet are also provided:

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf. The Shared Savings Program final rule can be downloaded at www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf on the Government Printing Office (GPO) website

E. TCOC Methodology: Required Elements for Specialized LTSS AEs

TCOC arrangements with specialized LTSS AEs must meet the following requirements, listed here and described in more detail below:

1. Defining a Historical Base
2. Required Adjustments to the Historical Base
3. TCOC Expenditure Target for the Performance Period
4. Actual Expenditures for the Performance Period
5. Shared Savings/(Loss) Pool Calculations
6. AE Share of Shared Savings/(Loss) Pool
7. Required Progression to Risk Based Arrangements

Note that the specialized LTSS AE Program is a pilot program and as such, EOHHS intends to engage in a systematic review of the guidelines established below as the program develops.

1. Defining a Historical Base

a. AE Specific Historical Cost Data

The TCOC historical base shall include three years of AE-specific historical cost data with equal weighting applied to each year. MCOs are strongly encouraged to use three years of historic data in creating the benchmark in order to stabilize the historic base; at a minimum, all existing AE experience must be utilized. For newly established AEs, the TCOC historical base can be created on a simulated attributed population identified using historical utilization data, as historical authorization data for the AE may not be available.

b. Covered Services

TCOC methodologies shall include all Medicaid costs associated with covered services listed in Attachment A that are included in EOHHS' contract with MCOs, with the clarifications/exceptions listed below. In addition, EOHHS intends to include equivalent Medicaid fee-for-service covered services for people not enrolled in managed care, for the performance year. Any further adjustments to covered services outside of those listed below must be requested in writing and pre-approved by EOHHS prior to MCO-AE contract execution for the affected contractual performance year:

- I. Exclude services currently covered under stop-loss provisions between EOHHS and the MCO;
- II. Exclude services managed by BHDDH for people with intellectual and development disabilities;
- III. Exclude long-stay/custodial nursing facility costs in excess of six consecutive months (disregarding any short-term acute hospital or skilled nursing facility stays that interrupt an otherwise continuous long-stay/custodial nursing facility stay);
- IV. Exclude HSTP performance incentive payments and CTC payments.
- V. Include and define any other infrastructure payments made by MCOs or EOHHS

to AEs and AE-affiliated providers.

c. Mitigation of Impact of Outliers: Claims threshold for high cost claims

TCOC data shall be adjusted to exclude costs in excess of \$100,000 per member per year. However, TCOC expenditures must include 10% of any annualized spending per member above the truncation threshold.

d. Adjusting for a Changing Risk Profile

To account for possible changes in the risk profile of an AE's attributed patient population over the historical base years, a risk adjustment methodology, using a clinical risk adjustment software, shall be applied. Under such an approach, risk calculations and any adjustments shall be applied at the total attributed population and not the EOHHS rate cell level. The TCOC methodology must describe the risk-adjustment method including underlying software parameters set by the MCO/payer. With EOHHS approval, adjustments using clinical and social risk factor data exogenous to the risk adjustment methodologies described above may be used. The MCO/payer may also propose an alternative approach to risk adjustment. The risk adjustment method must be equivalently provided to the MCO-enrolled and Medicaid fee-for-service populations within the AE. Information on risk adjustment methodologies shall be disclosed to contracting AEs.

e. Historical Base with Required Cost Trend Assumptions

When projecting (or trending) historical costs forward into the performance year, TCOC methodologies shall appropriately account for trends in nursing facility and home and community-based LTSS spending. Unless otherwise approved by EOHHS, trends assigned to TCOC baselines shall not exceed the final cumulative trends to the medical portion of Rhody Health Options rates for the nursing facility and the community LTSS capitation cells for Medicaid-only and Medicare-Medicaid populations contained in the EOHHS data books. The trends shall be applied to the AE in aggregate based on the AE's member mix.

2. Required Adjustments to the Historical Base

In order to prospectively establish an AE's TCOC Expenditure Target, the following adjustments to the historical base must be applied. No additional adjustments are allowed without prior approval from EOHHS. EOHHS anticipates that historic costs for members enrolled in the Medicare-Medicaid plan may require adjustment.

a. Adjustment for Prior Year Savings

The TCOC Expenditure Target must include an upward adjustment equal to an AE's share of prior year savings, after adjustment for quality performance, so that AEs have an opportunity to retain a portion of generated savings year over year. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target.

b. Adjustment for Historically Low-Cost AEs

Should any AE have three years of historical cost data demonstrating that risk-adjusted per capita spending for the AE's historically attributed patient population for TCOC covered services (see Attachment B) was significantly below the MCO average (statistically significant at $p \leq .05$), the MCO may adjust that AE's TCOC Expenditure Target upward by up to the percentage by which the TCOC fell below MCO average spending for the assessed historical time period. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target. This adjustment shall not be applied to entities with a historically attributed patient population for TCOC covered services that was significantly above the MCO average.

3. TCOC Expenditure Target for the Performance Period

Once an AE-specific, adjusted historical base is established, this base must be trended forward into the performance period to create an AE-specific TCOC Expenditure Target. TCOC methodologies shall be based on a performance time period of 12 months aligned with the state fiscal year. Initial contractual performance time periods may extend longer than 12 months if necessary.

a. Required Cost Trend Assumptions

The adjusted historical base must be cost trended to the performance year according to the LTSS cost trend assumptions described in Section E.1.e of this document.

b. Final Target Adjusted for Changes in the Attributed Population's Risk Profile

A risk adjustment methodology must be applied to assess any changes in an attributed population's risk profile from the risk-adjusted historical base to the contractual performance period, provided it can be equally applied to the MCO-enrolled and Medicaid fee-for-service populations within the AE. This methodology must be consistent with the LTSS risk adjustment methodology used in developing the adjusted historical base as described in Section E.1.d of this document.

4. Actual Expenditures for the Performance Period

a. Calculate Actual Expenditures Consistent with the Historical Base Methodology

Actual Expenditures for the Performance Period must be calculated consistent with the LTSS historical base methodology as described in Sections E.1.b and E.1.c of this document.

5. Shared Savings/(Loss) Pool Calculations

The Shared Savings/(Loss) Pool shall be calculated as the difference between Actual Expenditures (Section E.4) and the TCOC Expenditure Target (Section E.3), after the following adjustments:

a. Small Sample Size Adjustment for Random Variation: Minimum Savings (Loss) Rate

Shared savings calculations are intended to provide an incentive for outcomes based on performance. There is a methodological challenge posed in differentiating results based on performance versus random variation. In the calculations for comprehensive AE TCOC projections, an accommodation is made to adjust for the impact of random variation in

small populations. Given the smaller sizes in the attributed populations of the specialized LTSS AEs, there is a higher likelihood of volatility in shared savings pool calculations. EOHHS is continuing to review potential approaches to stabilizing the shared savings pool calculations. The method outlined here is preliminary pending further examination and input.

Given the smaller attributed populations expected to be attributed to specialized LTSS AEs, it is necessary to account for statistical uncertainty in performance measurement due to the effect of random variation in utilization and spending. Specialized LTSS AEs will be subject to a 4% Minimum Savings (Loss) Rate. A specialized LTSS AE must achieve shared savings of greater than or equal to 4% of the TCOC Expenditure Target in order to be eligible for shared savings. Where the AE is responsible for downside risk, the AE will share in losses if the shared loss rate is greater than or equal to 4% of TCOC Expenditure Target. During the pilot, EOHHS will assess the effectiveness of the Minimum Savings (Loss) Rate for the specialized LTSS AE program and may make changes to the adjustment or develop an alternative approach to better account for random variation. These approaches may include, but are not limited to, exclusion of low frequency high-cost services and separate calculations for higher cost conditions.

b. Impact of Quality and Outcomes

The Shared Savings/(Loss) Pool shall be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. An Overall Quality Score will be generated for each AE, according to the methodology detailed in Attachment B: Quality Framework and Methodology for Comprehensive and Specialized LTSS Accountable Entities. The Shared Savings/(Loss) Pool must be multiplied by the Overall Quality Score.

c. Adjustment for MCO Enrollment³

The Shared Savings/(Loss) Pool will be adjusted based on the percentage of member months that the AE's attributed population is enrolled in managed care. With EOHHS approval, an MCO may apply a risk adjustment methodology to account for differences in the risk of the MCO-enrolled and Medicaid fee-for-service populations.

d. Maximum Allowable Shared Savings/(Loss) Pool

³ The TCOC methodology may include MCO-enrolled and Medicaid fee-for-service populations to increase the reliability and validity of the TCOC calculations for the specialized LTSS AEs. However, EOHHS does not have federal authority to distribute shared savings payments to AEs for Medicaid beneficiaries who are not enrolled in managed care. As a result, the TCOC methodology adjusts for the proportion of a specialized LTSS AE's attributed population that is enrolled in managed care. In contrast, specialized LTSS AEs will be eligible to earn Incentive Payments based on the AE's performance relative to the AE's TCOC Expenditure Target for its total attributed population, which includes MCO-enrolled and Medicaid fee-for-service beneficiaries. As articulated in the Incentive Program Requirements, 20% of the specialized LTSS AE Specific Incentive Pool shall be set aside to support potential shared savings achieved by an AE relative to the AE's TCOC Expenditure Target, without adjustment for MCO Enrollment.

In any given performance year, the Shared Savings Pool must not exceed 10% of the AE's contract revenue. In instances where the AE is responsible for downside risk, the Shared Loss Pool must not exceed 5% of the AE's contract revenue.

6. AE Share of Savings (Loss) Pool

In Year 1, AEs may be eligible to retain up to 40% of the Shared Savings Pool, as defined in Section E.5 above. AEs assuming downside risk may be eligible for up to 60% of the Shared Savings Pool, and may be responsible for up to 60% of the Shared Loss Pool. However, no specialized LTSS AEs will be eligible to assume downside risk in the first year of the AE program. EOHHS will issue additional requirements in the future on downside risk arrangements for specialized LTSS AEs.

| Specialized LTSS AE Shared Savings Model | AE Share of Savings | Maximum Allowable Shared Savings Pool | Maximum Allowable Shared Loss Pool | AE Share of Losses |
|--|---------------------------|---------------------------------------|------------------------------------|--------------------|
| Shared savings only | Up to 40% of Savings Pool | 10% of AE contract revenue | NA | NA |

7. Required Progression to Risk Based Arrangements

It is anticipated that, over time, shared savings and incentive opportunities will be in relation to shared risk. AEs will be expected to move into downside risk arrangements within four to five years of the launch of the specialized LTSS AE program. After five years, development and implementation funding will end, and AEs will be sustained going forward based on their successful performance and associated financial rewards in accordance with their MCO contract(s).

EOHHS has defined “meaningful risk” based on learnings from other states, Office of the Health Insurance Commissioner (OHIC) requirements, and federal MACRA rules. Marginal risk and loss caps are defined with a range, EOHHS anticipates that smaller organizations will fall on the lower end of that range. The required progression of increasing risk for all specialized LTSS AEs is as follows:

| | Marginal Risk <i>AE Share of Losses</i> | Loss Cap <i>Maximum Shared Loss Pool</i> |
|-------------------|--|---|
| <i>Definition</i> | <i>The percentage of any Shared Loss Pool for which the AE is financially at risk.</i> | <i>The maximum percentage of the AE's contract revenue for which the AE is financially at risk.</i> |
| Year 1 | 0 | NA |
| Year 2 | 0 | NA |
| Year 3 | 0 | NA |

| | | |
|--------|--------------------------------|---------------------------------|
| Year 4 | 15-30% of any Shared Loss Pool | At least 2% No more than 10% |
| Year 5 | 30-50% of any Shared Loss Pool | At least 2% No more than 10% |

It is

EOHHS's intent to align risk requirements with the standards established by the Office of the Health Insurance Commissioner (OHIC) to the extent possible. Alternatives for larger organizations or entities that include a hospital may be considered in the future.

In the event of a shared risk arrangement with an AE, it is necessary to ensure that the AE has the capacity to pay for its share of any losses. To accomplish this the MCO shall utilize a withhold to ensure that funds are available for financial settlement with the AE in the event that medical expenses exceed the total cost of care projection for the performance period. At a minimum, the withhold must capture 75 percent of the maximum shared loss pool. MCO's final settlement with the AE with regard to a withhold is based on actual experience in relation to the TCOC calculation.

Should an MCO and AE wish to share risk on a more accelerated schedule than that outlined above, the MCO and AE shall submit written documentation to EOHHS, including:

- the draft contractual financial terms between the parties;
- a statement of why the AE is qualified to assume greater risk than that outlined above, including its infrastructure to manage clinical risk, an established record of meeting quality metrics, and the likelihood that the AE will meet the quality thresholds established by EOHHS and the MCO;
- documentation of secured funds necessary to meet the maximum financial obligation that the AE could potentially incur under the terms of the proposed agreement.

EOHHS together with state partners (e.g. DBR and OHIC), will review the aforementioned information, and decide as to whether the arrangement may proceed.

Additionally, if an AE enters into an arrangement that provides for shared losses with a total potential risk that equals or exceeds 10% of expected expenditures, the AE must meet all of the financial reserve and risk-based capital requirements required of an MCO, with oversight by the Department of Business Regulation.⁴ EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three months of claims.⁵

⁴ As specified in the standards for minimum risk-based capital (RBC) requirements for health organizations in Chapter 27-4.7 of the RI general statute. <http://webserver.rilin.state.ri.us/Statutes/Title27/27-4.7/INDEX.HTM>

⁵ Note that CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. For ease of reference links to relevant State Medicaid Director Letters are provided: www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf; www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf. Links for the Medicare Shared Savings Program final rule and a CMS Factsheet are also provided: www.cms.gov/Medicare/Medicare-Fee-for-

F. TCOC Development Approval and Reporting Process

1. TCOC Development Approval

Medicaid MCOs and AEs must establish TCOC calculation methodologies in accordance with these requirements to serve as the basis for their shared savings and/or risk arrangements. These methodologies must be approved by EOHHS. EOHHS will review the MCO's TCOC methodologies and reserves the right to ask for modifications before granting approval.⁶ EOHHS also reserves the right to review these methodologies on an annual basis. EOHHS' approval, denial, or requests for amendment will be transmitted in writing, without unreasonable delay. Further, for specialized LTSS AEs, the TCOC calculation methodologies must be equivalently applied to the MCO-enrolled and Medicaid fee-for-service populations if both are included in the AE.

MCOs must submit details of their TCOC methodologies to EOHHS for approval in writing, in advance of contracting with AEs. Applications must document and demonstrate specific compliance with the requirements outlined in Sections C, D, and E of these requirements. Simple numerical examples may be helpful. Applications must also include comprehensive answers to the questions below:

1. Benchmark Time Period

What is the time period for the historical data used to establish an AE's cost benchmark? How does the methodology account for attributed patients for whom no historical data is available?

2. Benchmark Data Source

What data sources are used to establish an AE's cost benchmark?

3. Mid-Year Changes

How does the TCOC calculation account for month-to-month changes in MCO enrollment and/or PCP assignment/specialized LTSS AE attribution, whether during benchmark years or the performance year? How does the TCOC calculation account for month-to-month changes in the PCP/LTSS provider roster of an AE, whether during benchmark years or the performance year?

4. Risk Adjustment

What risk adjustment methodology will be applied to assess changes in the risk profile of an AE's attributed patient population, over the historic base years, and between the historic base and

[Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf](#). The Shared Savings Program final rule can be downloaded at www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf on the Government Printing Office (GPO) website

⁶ In addition to this EOHHS requirement, note that depending on circumstances transparency in such arrangements is specifically required in CFR42 §438.6 Contract requirements 438.6(g): Inspection and audit of financial records – Risk contracts must provide that the state agency and the Department may inspect and audit any financial records of the entity or its subcontractors. 438.6(h) Physician Incentive plans – MCO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210 of this chapter. 436.6(k) All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

performance period? If a clinical risk adjustment software will be utilized, provide a detailed description of the underlying software parameters.

5. Shared Savings/Loss Distribution Rate and Calculation

What portion of the eligible shared savings pool (after accounting for scaling based on quality and outcomes metrics) will be distributed to the AE?

6. Shared Savings/Loss Distribution Timing

At what time are shared savings distributions made to qualifying AEs? If distributions are made more frequently than annually, please also describe any true-up processes.

7. Alignment between MCO and FFS populations (Specialized AEs only)

Can the TCOC methodology be applied equally to MCO and Medicaid fee-for-service populations within a single specialized LTSS AE?

Where appropriate, MCOs should respond separately to the questions for comprehensive and specialized LTSS AEs. Material amendments to TCOC methodology must be approved by EOHHS in advance. If an MCO utilizes a TCOC methodology that differs in any respect from the approved methodology, EOHHS reserves the right to calculate risk- and gain-share with the MCO as if the approved methodology had been utilized, and the MCO shall provide EOHHS with all information necessary to make that calculation.

MCOs must complete and submit the *MCO/AE TCOC Reporting Template* as defined by EOHHS for each AE within 15 days, at the latest, of executing any AE contract. If any entity is certified and contracted as both a comprehensive AE and a specialized LTSS AE, separate comprehensive AE and specialized LTSS AE templates must be completed for the entity.

2. Required Ongoing Reporting

In order to monitor AE financial performance, AEs and MCOs will be required to furnish financial reports regarding risk performance on a quarterly basis to EOHHS. Quarterly reports must be submitted to EOHHS within 120 days of the close of the quarter, as detailed below.

| Performance Period 1: Performance Quarters | Quarterly Report Due to EOHHS |
|---|-------------------------------|
| Q1: Jan 1 st – Mar 31 st 2018 | July 29 th 2018 |
| Q2: Apr 1 st – Jun 30 th 2018 | October 28 th 2018 |
| Q3: Jul 1 st – Sep 30 th 2018 | January 28 th 2018 |
| Q4: Oct 1 st – Dec 31 st 2018 | April 29 th 2018 |
| Q5: Jan 1 st – Mar 31 st 2019 | July 29 th 2019 |
| Q6: Apr 1 st – Jun 30 th 2019 | October 28 th 2019 |

G. Other APMs for Specialized LTSS AEs

Currently, most Medicaid nursing facility and home and community-based LTSS in Rhode Island are reimbursed using encounter-based and other fee-for-service payment models that do not reward quality, efficiency, or value. EOHHS seeks to move away from fee-for-service payment models toward alternative payment models (APMs) that incentivize providers to be more accountable for Medicaid patients' care and outcomes. EOHHS intends to pilot test APMs, including bundled payments, per member per month (PMPM) payments, episodic payments, and other value-based payment (VBP) models, on a voluntary basis with Partner and Affiliate Providers in specialized LTSS AEs. EOHHS anticipates requesting expenditure authority under Section 1115(a)(2) of the Social Security Act to implement APMs for nursing facility and home and community-based LTSS. Additional requirements around the APMs and the APM pilot opportunities will be provided separately.

H. Comprehensive AE TCOC Methodology Example

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Adjustment Details

1 Historical Base and Initial TCOC Target Adjustments

| | | | | | | |
|---|--|-----------|-------------|-----------|-----------------------------|--|
| | | Year 1 | Year 2 | Year 3 | Historical Base | |
| Risk Adj | E Average Risk Score | 0.95 | 0.97 | 0.99 | 0.98 | <- INPUT |
| | TCOC (Dollars): Years 1 and 2 Risk-Adjusted to Year 3 Risk Mix | \$359.53 | \$354.15 | \$320.00 | \$334.20 | |
| | Risk Adjustment | \$14.53 | \$7.15 | \$0.00 | \$3.60 | |
| Adjustment for Prior Year Savings | G Prior Year Savings: Target - Actual TCOC (ppm) | | | \$7.00 | <- INPUT | |
| | Eligible Adjustment: AE Share | | | \$2.80 | 40% | AE Share |
| | Eligible Adjustment: Total Dollars | | | \$176,400 | | |
| | Maximum Adjustment for Prior Year Savings (2%) | | | \$408,240 | | 2% Max Allowable |
| | Eligible Adjustment or Max Allowable | | | \$176,400 | | |
| Historical Performance Adjustment | H MCO Average Cost (ppm) | | | \$334.00 | <- INPUT | |
| | MCO Average Risk Score | | | 1.00 | | |
| | AE Average Risk Score | | | 0.99 | | |
| | AE Cost (ppm) | | | \$320.00 | | |
| | AE Cost with FQHC PPS Adjustment (ppm) | | | \$320.00 | \$0.00 | FQHC PPS Adjustment (ppm), if applicable |
| | AE Average Risk Normalized Cost (ppm) | | | \$323.23 | | |
| | Cost Score (% above/below MCO Average) | | | -4% | | |
| | Eligible Adjustment | | | \$13.84 | | |
| | Eligible Adjustment: Total Dollars | | | \$855,593 | | |
| | Max Allowable Adjustment | | | \$408,240 | | 2% Max Allowable |
| | Eligible Adjustment or Max Allowable | | | \$408,240 | | |
| 2 Final TCOC Target Adjustments | | | | | | |
| | | PY | | | | |
| Risk Adj | A Average Risk Score | 1.01 | <- INPUT | | | |
| | Risk Adjustment | \$7.29 | | | | |
| 3 Shared Savings (Loss) Pool Adjustments | | | | | | |
| Small Sample Size Random Variation Adjustment | C Shared Savings (Loss) Adjustment Factor Parameters by AE Size and Savings Rate | | | | | |
| | | Small AE | Medium AE | Large AE | | |
| | Savings % | (5-9,999) | (10-19,999) | (20,000+) | | |
| | 1% | 73% | 79% | 89% | | |
| | 2% | 82% | 92% | 97% | | |
| | 3% | 91% | 97% | 99% | | |
| | 4% | 95% | 99% | 100% | | |
| | 5% | 98% | 100% | 100% | | |
| | 6% | 99% | 100% | 100% | | |
| | Parameter Lookup | | | | | |
| | Savings % | 4.87% | 5.00% | 5.00% | Savings Rate Bracket Lookup | |
| | Small AE | 98% | | | | |
| | Medium AE | 100% | | | | |
| | Large AE | 100% | | | | |
| | Random Variation Adjustment | 98% | | Small AE | AE Size Classification | |
| Quality Adj | D Quality Score Multiplier | | | 1.00 | <- INPUT | |
| | Detailed Quality Measure Scoring Methodology to come | | | | | |

- 1 TCOC inputs must account for covered service exclusions and claims cap truncation
- 2 Base Year Weights are flexible, example uses MSSP methodology
- 3 Placeholder trend, to populate OHHS data book trends, Year 2 trend = Year 2/Year 1
- 4 Change compounding formula based on time period between Base Year 3 and Performance Year (assumes 2 year period)

I. Specialized LTSS AE TCOC Methodology Example

| OHHS Specialized AE Total Cost of Care (TCOC) Guidance | | | | | | AE Specific Variables |
|--|---|--------------|--------------|--------------|------------------|--------------------------------|
| Specialized AE TCOC Calculation Tool | | | | | | Calculation Variables |
| *Note: All data is illustrative only | | | | | | |
| | | SFY 2014 | SFY 2015 | SFY 2016 | SFY 2018 | |
| AE Specific Historical Data Input: Membership and Cost | | Year 1 | Year 2 | Year 3 | Historical Base | Performance Year |
| INPUT -> | Attributed Lives (Members) | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 |
| INPUT -> | PMPM | \$1,225.00 | \$1,250.00 | \$1,275.00 | \$1,262.50 | \$1,225.00 |
| | | | | | | |
| 1 Calculating the Historical Base and Initial TCOC Target | | | | | | |
| | | Year 1 | Year 2 | Year 3 | Historical Base | Performance Year Target |
| | | | | | \$ | pmpm |
| A Total Cost of Care (Unadjusted) | | \$14,700,000 | \$15,000,000 | \$15,300,000 | \$15,150,000 | \$1,262.50 |
| B Base Year Weight | | 10% | 30% | 60% | | |
| C Trend Factor | | | 2% | 2% | | |
| D Trend Adjustment | | \$593,880 | \$300,000 | \$0 | \$149,388 | \$12.45 |
| Details below | E Risk Adjustment | \$0 | \$0 | \$0 | \$0 | \$0.00 |
| F Total Cost of Care (Adjusted) | | \$15,293,880 | \$15,300,000 | \$15,300,000 | \$15,299,388 | \$1,274.95 |
| Details below | G Prior Year Savings Adjustment | | | \$303,000 | \$303,000 | \$25.25 |
| Details below | H Historical Performance Adjustment | | | \$303,000 | \$303,000 | \$25.25 |
| I Total Cost of Care (Adjusted, with Sustainability Adjustments) | | | | | \$15,905,388 | \$1,325.45 |
| J Total Cost of Care (Initial Target) | | | | | | |
| | | | | | | Projected Trend |
| | | | | | | Time Period (Yrs) |
| | | | | | | 2% |
| | | | | | | 2 |
| | | | | | | \$16,547,966 |
| | | | | | | \$1,379.00 |
| | | | | | | TOCOC Initial PY Target |
| | | | | | | |
| 2 Calculating the Final TCOC Target | | | | | | |
| A Risk Adjustment | | | | | \$0 | \$0.00 |
| B *Final Target based on risk-adjusted PMPM with performance year membership | | | | | \$0 | \$0.00 |
| | | | | | | Impact of change in membership |
| Total Cost of Care (Final Target) | | | | | | \$16,547,966 |
| | | | | | | \$1,379.00 |
| | | | | | | TOCOC Final PY Target |
| | | | | | | |
| 3 Calculating and Distributing the Shared Savings (Loss) Pool | | | | | | |
| | | | | | Performance Year | |
| | | | | | \$ | pmpm |
| A Total Cost of Care (Actual Expenditures) | | | | | \$14,700,000 | \$1,225.00 |
| | | | | | | TOCOC Actual |
| B Shared Savings (Loss) Pool | | | | | \$1,847,966 | \$154.00 |
| C Shared Savings Pool | | | | | \$1,847,966 | \$154.00 |
| D Shared Loss Pool | | | | | NO | NO |
| Details below | E Shared Savings Pool After MSR | | | | \$1,847,966 | \$154.00 |
| F Shared Loss Pool After MLR | | | | | NO | NO |
| G Quality and Outcomes Adjustment: Quality Score Multiplier | | | | | 1.00 | |
| H Shared Savings Pool (Adjusted) | | | | | \$1,847,966 | \$154.00 |
| I Shared Loss Pool (Adjusted) | | | | | NO | NO |
| J Adjustment for MCO Enrollment (% MCO Member Months) | | | | | 50% | |
| K Eligible MCO-Adjusted Shared Savings Pool | | | | | \$923,983 | \$77.00 |
| L Eligible MCO-Adjusted Shared Loss Pool | | | | | NO | NO |
| Cap: 10% AE Contract | M Maximum Allowable MCO Shared Savings Pool | | | | \$827,398 | \$68.95 |
| Cap: 5% AE Contract | N Maximum Allowable MCO Shared Loss Pool | | | | \$413,699 | -\$34.47 |
| O Final MCO Shared Savings Pool | | | | | \$827,398 | \$68.95 |
| P Final MCO Shared Loss Pool | | | | | NO | NO |
| | | | | | | |
| Q AE Share of Final Shared Savings (Loss) Pool | | | | | | |
| R Option 1 AEs: Shared Savings Only | | AE Share | 20% | 30% | 40% | |
| | | | \$ | pmpm | \$ | pmpm |
| Shared Savings | | | \$165,480 | \$13.79 | \$248,219 | \$20.68 |
| | | | | | \$330,959 | \$27.58 |

| Adjustment Details | | | | | |
|--|-----|--|------------|-----------------------|------------|
| 1 Historical Base and Initial TCOC Target Adjustments | | | | | |
| Risk Adj | E | Average Risk Score | Year 1 | Year 2 | Year 3 |
| | | | 1.0 | 1.0 | 1.0 |
| | | TCOC (Dollars): Years 1 and 2 Risk Adjusted to Year 3 Risk Mix | \$1,225.00 | \$1,250.00 | \$1,275.00 |
| | | Risk Adjustment | \$0.00 | \$0.00 | \$0.00 |
| Adjustment for Prior Year Savings | G | Prior Year Savings: Target - Actual TCOC (pmpm) | | | \$65.00 |
| | | Eligible Adjustment: AE Share | | | \$26.00 |
| | | Eligible Adjustment: Total Dollars | | | \$312,000 |
| | | Maximum Adjustment for Prior Year Savings (2%) | | | \$303,000 |
| | | Eligible Adjustment or Max Allowable | | | \$303,000 |
| Historical Performance Adjustment | H | MCO Average Cost (pmpm) | | | \$1,350.00 |
| | | MCO Average Risk Score | | | 1.0 |
| | | AE Average Risk Score | | | 1.0 |
| | | AE Cost (pmpm) | | | \$1,275.00 |
| | | AE Average Risk Normalized Cost (pmpm) | | | \$1,275.00 |
| | | Cost Score (% above/below MCO Average) | | | -6% |
| | | Eligible Adjustment | | | \$70.14 |
| | | Eligible Adjustment: Total Dollars | | | \$841,667 |
| | | Max Allowable Adjustment | | | \$303,000 |
| | | Eligible Adjustment or Max Allowable | | | \$303,000 |
| 2 Final TCOC Target Adjustments | | | | | |
| Risk Adj | | | PY | | |
| | A | Average Risk Score | 1.00 | | < INPUT |
| | | Risk Adjustment | \$0.00 | | |
| 3 Shared Savings (Loss) Pool Adjustments | | | | | |
| MSR/ MLR | F/F | Application of Minimum Shared Savings (Loss) Rate | | | |
| | | Minimum Savings (Loss) Rate | 4.0% | Targeted Expenditures | |
| | | Minimum Savings | \$661,919 | \$55.16 | |
| | | Minimum Loss | -\$661,919 | -\$55.16 | |

- 1 TCOC inputs must account for covered service exclusions and claims cap truncation
- 2 Base Year Weights are flexible, example uses MSSP methodology
- 3 Placeholder trend, to populate OHHS data book trends, Year 2 trend = Year 2/Year 1
- 4 Change compounding formula based on time period between Base Year 3 and Performance Year (assumes 2 year period)

Attachment A: Services Included in Specialized LTSS AE TCOC Analyses

Homemaker
Environmental Modifications
Special Medical Equipment
Minor Environmental Modifications
Meals on Wheels
Personal Emergency Response (PERS)
LPN Services (Skilled Nursing)
Home Health Services (skilled)
Skilled Therapies (PT, OT, Speech)
Community Transition Services
Residential Supports
Day Supports
Supported Employment
Supported Living Arrangements/Shared Living
Private Duty Nursing
Adult Companion
Assisted Living
Personal Care Assistance/Certified Nursing Assistant (CNA)/Attendant Care Services
Respite
Habilitative Services
Adult Day Services
Long Stay Nursing Facility
Hospice
Skilled Nursing Facility (SNF)

Attachment B: Quality Framework and Methodology for Comprehensive and Specialized LTSS Accountable Entities

A. Principles and Quality Framework

A fundamental element of the EOHHS Accountable Entity (AE) program, and specifically the transition to alternative payment models, is a focus on quality and outcomes. Measuring and rewarding quality as part of a value based model is critical to ensuring that quality is maintained and/or improved while cost efficiency is increased. As such, the payment model must be designed to both recognize and reward historically high-quality AEs while also creating meaningful opportunities and rewards for quality improvement. This model must be measurable, transparent and consistent, such that participants and stakeholders can view and recognize meaningful improvements in quality as this program unfolds.

As a starting point, the Year 1 requirements described below are intended to provide an interim structure that permits baseline measurement and assessment, while allowing for future refinements that continuously “raise the bar” toward critical improvements in quality and outcomes.

B. Shared Savings Opportunity

Medicaid AEs are eligible to share in earned savings based on a quality multiplier to be determined as follows:

- The AE must meet the established total cost of care (TCOC) threshold as determined using the EOHHS approved TCOC methodology to be eligible for shared savings.
- The quality measures included as part of the Medicaid Accountable Entity Common Measure Slate (including up to 4 additional optional menu measures for comprehensive AEs) will be used to determine a quality score for each AE.
- For comprehensive AEs, all admin (claims-based) measures must be generated and reported by the MCO. AEs must provide the necessary data to the MCO to generate any hybrid or EHR-only measures. Any EHR-only measures generated by an AE may be reported for the AE’s full attributed population.
- For specialized LTSS AEs, measures must be generated for an AE’s entire Medicaid attributed population, including MCO-enrolled and not enrolled beneficiaries.
- The quality score will be used as a multiplier to determine the percentage of the shared savings pool the AE is eligible to receive. Quality scores will be calculated distinctly for each MCO with which the AE is contracted.
- Performance year periods, which are aligned with the state fiscal year calendar, will be tied to the calendar year quality performance period ending within the performance year period. The prior calendar year quality performance period will serve as the benchmark period, as shown below.

| Performance Year | Performance Time Period | Quality Measurement Performance Period | Quality Measurement Benchmark Period | Payment |
|------------------|-------------------------|--|--------------------------------------|----------|
| PY 1 | SFY 2019* | HEDIS 2019, CY 18 | HEDIS 2018, CY 17 | SFY 2020 |
| PY 2 | SFY 2020 | HEDIS 2020, CY 19 | HEDIS 2019, CY 18 | SFY 2021 |
| PY 3 | SFY 2021 | HEDIS 2021, CY 20 | HEDIS 2020, CY 19 | SFY 2022 |
| PY 4 | SFY 2022 | HEDIS 2022, CY 21 | HEDIS 2021, CY 20 | SFY 2023 |

*Performance Year 1 may be an extended performance period to allow for differential start dates; as such it must begin no earlier than January 1, 2018 and no later than July 1, 2018 and must end on June 30, 2019.

C. Medicaid AE Common Measure Slate for Comprehensive AEs

For comprehensive AEs, EOHHS requires the use of the measures included in the Medicaid Comprehensive AE Common Measure Slate (see below). In addition to the 11 required core measures, each MCO and AE may include up to 4 additional optional measures identified by the MCO and AE from the RI State Innovation Model (SIM) menu measure set and/or Medicaid Child and/or Adult Core Set.

Note that EOHHS may define an additional member retention measure for piloting in Year 1, and full implementation beginning in Year 2.

The Common Measure Slate for comprehensive AEs has been developed with the following considerations:

- Alignment with the RI SIM core measure set.
- Cross cutting measures across multiple domains with a focus on clinical/chronic care, behavioral health, and social determinants of health.
- Feasibility of data collection and measurement and minimization of administrative burden.
- A minimum number of measures necessary to enable a concentrated effort and meaningful assessment of quality.
- Focus on statewide strategic priorities outlined by EOHHS, RI Department of Health, RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, and the Office of the Health Insurance Commissioner.

D. Comprehensive AE Quality Score Determination

Part 1: Relative Weight of Individual Measures for Comprehensive AEs

The Quality Score is to be developed based on assigning a weight to each individual measure. Measure weighting is subject to negotiation between the MCO and AE, but must meet the following requirements:

- Measures for which the AE's baseline meets or exceeds the current Medium benchmark cannot exceed 10% weight,
- Measures with no baseline cannot exceed 10% weight, and
- The Social Determinants of Health (SDOH) Screen measure must be assigned a 10% weight.

Mandatory measures for which baseline data can be calculated will be pay for performance in Year 1. A Measure Score will be generated for each measure according to the criteria specified below in Section E Part 2.

The following four mandatory measures, for which baseline data is not available, will be pay for reporting in Year 1:

- Measure 5. Tobacco Use: Screening and Cessation Intervention
- Measure 9. Screening for Clinical Depression & Follow-up Plan
- Measure 10. Social Determinants of Health (SDOH) Screen
- Measure 11. Self-assessment/rating of health status

A pass/fail score (either 100% or 0%) will be awarded for these measures, based on timely submission of required data in accordance with agreed upon formats. There will be no partial credit for reporting. Year 1 data will be used to establish a baseline for these measures.

Optional admin (claims-based) measures must be pay for performance in Year 1. Optional hybrid or EHR-only measures may be pay for performance or pay for reporting in Year 1.

The overall Quality Score must be a sum of the Measure Specific Quality Score times the Measure Weight for each measure.

Example:

| List of Measures | Measure Specific Quality Score | Measure Weight | Measure Specific Quality Score * Measure Weight |
|------------------|--------------------------------|----------------|---|
| Measure 1 | 100% | 20% | 20% |
| Measure 2 | 100% | 20% | 20% |
| Measure 3 | 75% | 20% | 15% |
| Measure 4 | 50% | 30% | 15% |
| Measure 5 | 0% | 10% | 0% |

| | |
|------------------------------|------------|
| Overall Quality Score | 70% |
|------------------------------|------------|

Part 2) Comprehensive AE Measure Specific Performance

Measure specific performance is intended to both reward historically high-quality providers and create opportunities for low performers to benefit from improvement.

For each measure included in the Measure Slate, two measure specific benchmark targets are established based on NCQA Medicaid Quality Compass data.

- High benchmark target: NCQA Medicaid Quality Compass percentile measure score defined by measure based on current MCO performance (see Common Measure Slate for measure specific benchmarks)
- Medium benchmark target: NCQA Medicaid Quality Compass 66th percentile measure score for all measures

For those measures for which NCQA Medicaid Quality Compass data is not available, a Medicaid statewide median benchmark will be generated, and a High and Medium benchmark target will be established.

Each measure must be assessed and scored based on performance relative to the benchmark targets or achievement of meaningful improvement, as defined below.

Comprehensive AE Measure Specific Scoring

| Measure Performance Category | Measure Score | Performance Category Criteria |
|------------------------------|---------------|--|
| High Performance | 100% | AE score meets or exceeds the High benchmark target |
| Medium Performance | 75% | AE score meets or exceeds the Medium benchmark target (but is below the High benchmark target) |
| Improvement | 50% | AE score is below the Medium benchmark target but shows meaningful improvement over the prior year's performance. Meaningful improvement is defined as improvement half way from the AE's baseline to the Medium performance target, or 10 percentage point improvement, whichever is lower, with a minimum required improvement of at least 3 percentage points. |
| Fail | 0% | AE score is below the Medium benchmark target and does not show meaningful improvement over the prior year's performance, as defined above. |

Example: Comprehensive AE Measure 1. Breast Cancer Screening

High Benchmark = 65.06 (75th Percentile NCQA Quality Compass)

Medium Benchmark = 63.10 (66th Percentile NCQA Quality Compass)

| AEs | Year 1 Score | Year 2 Score | AE Performance Category | Measure Specific Score |
|------|--------------|--------------|-------------------------|------------------------|
| AE 1 | 66% | 68% | High Performance | 100% |
| AE 2 | 62% | 64% | Medium Performance | 75% |
| AE 3 | 55% | 60% | Improvement | 50% |
| AE 4 | 50% | 52% | Fail | 0% |

Proposed Comprehensive AE Common Measure Slate*

| Measure Name | NQF # | Measure Steward | Measure Domain | Measure Source | Measure Description | Age Cohort | High Benchmark | Medium Benchmark |
|---|-------|-----------------|-----------------|-----------------|---|------------|--------------------------------|--------------------------------|
| 1. Breast Cancer Screening | 2372 | HEDIS® | Preventive Care | Admin | The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer | Adult | QC 75th percentile | QC 66 th percentile |
| 2. Weight Assessment & Counseling for Physical Activity, Nutrition for Children & Adolescents | 0024 | HEDIS® | Preventive Care | Hybrid | The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/Gyn and who had evidence of the following during the measurement year: BMI percentile, Counseling for Physical Activity and Nutrition | Pediatric | QC 90 th percentile | QC 66 th percentile |
| 3. Developmental Screening in the 1 st Three Years of Life | 1448 | OHSU | Preventive Care | Admin or Hybrid | The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life; this is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age | Pediatric | 65% score | 50% score |

*Measures are subject to change based on the recommendations of OHIC's Measure Alignment Review Committee

| Measure Name | NQF # | Measure Steward | Measure Domain | Measure Source | Measure Description | Age Cohort | High Benchmark | Medium Benchmark |
|---|-------|-----------------|-----------------|-----------------|---|------------|--------------------------------|--------------------------------|
| 4. Adult BMI Assessment | N/A | HEDIS® | Preventive Care | Hybrid | The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement or the year prior to the measurement year | Adult | QC 90 th percentile | QC 66 th percentile |
| 5.Tobacco Use: Screening and Cessation Intervention | 0028 | AMA-PCPI | Preventive Care | Admin or Hybrid | Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user | Adult | N/A Reporting only in Y1 | N/A Reporting only in Y1 |
| 6. Comp. Diabetes Care: HbA1c Control (<8.0%) | 0575 | HEDIS® | Chronic Illness | Hybrid | The percentage of members 18-75 years of age with diabetes (type 1 and 2) w/HbA1C control <8.0% | Adult | QC 75 th percentile | QC 66 th percentile |
| 7.Controlling High Blood Pressure | 0018 | HEDIS® | Chronic Illness | Hybrid | <p>The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria:</p> <ul style="list-style-type: none"> • 18-59 years of age whose BP was <140/90 mm Hg • 60-85 years of age with a dx of diabetes whose BP was <140/90 mm Hg • 60-85 years of age without a dx of diabetes whose BP was <150/90 mm Hg | Adult | QC 90 th percentile | QC 66 th percentile |

| Measure Name | NQF # | Measure Steward | Measure Domain | Measure Source | Measure Description | Age Cohort | High Benchmark | Medium Benchmark |
|--|-------|-----------------|---------------------|-------------------|--|---------------------|--------------------------------|--------------------------------|
| 8. Follow-up after Hospitalization for Mental Illness (7 Days) | 0576 | HEDIS® | Behavioral Health | Admin | The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnosis and who had a follow-up visit with a mental health practitioner | Adult and Pediatric | QC 90 th percentile | QC 66 th percentile |
| 9. Screening for Clinical Depression & Follow-up Plan | 0418 | CMS | Behavioral Health | Practice-reported | Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented | Adult and Pediatric | N/A Reporting only in Y1 | N/A Reporting only in Y1 |
| 10. Social Determinants of Health (SDOH) Screening | N/A | N/A | Social Determinants | | % of members screened as defined per the SDOH elements in the Medicaid AE certification standards* | Adult and Pediatric | N/A | N/A |
| 11. Self-Assessment/Rating of Health Status | N/A | N/A | | | Measure to be defined and submitted to EOHHS for approval (e.g., Institute for Healthcare Improvement) | Adult and Pediatric | N/A | N/A |

Technical specifications for the measures above will be provided separately.

* Section 5.2.2 of the AE Certification Standards requires that each AE:

“Together with partner MCOs, develop, implement, and maintain procedures for completing an initial SDOH Care Needs Screening for Attributed Members based on a defined protocol.... The screening shall evaluate Attributed Members’ health-related social needs in order to determine the need for social service intervention. Such services shall include but not be limited to:

- *Housing stabilization and support services;*
- *Housing search and placement;*
- *Food security;*
- *Support for Attributed Members who have experience of violence.*
- *Utility assistance;*
- *Physical activity and nutrition;...*”

Optional Menu Metrics for Comprehensive AEs

Select no more than 4 measures from the SIM Menu Measure Set and/or the Medicaid Child and/or Adult Core Quality Measure Set.



E. Medicaid AE Common Measure Slate for Specialized LTSS AEs

For specialized LTSS AEs, EOHHS requires the use of all measures included in the Medicaid Specialized LTSS AE Common Measure Slate (see below). The Common Measure Slate for specialized LTSS AEs has been developed with the following considerations:

- Cross cutting measures across multiple domains with a focus on LTSS, healthy aging, behavioral health, and social determinants of health.
- Feasibility of data collection and measurement and minimization of administrative burden.
- A focused set of measures that will enable a concentrated effort and meaningful assessment of quality.
- Focus on statewide strategic priorities outlined by EOHHS and the RI Division of Elderly Affairs.

F. Specialized LTSS AE Quality Score Determination

Year 1: Unlike the Comprehensive AEs, the SIM measure set does not specifically include a set of LTSS-related measures. As such, there is a strong emphasis on reporting and establishing baseline data for the measures in the first year of the specialized LTSS AE program. All measures must be reported using EOHHS measure specifications (to be released separately). For Year 1, all measures included in the Measure Slate will be assigned a weight and included in the Overall AE Quality Score for each AE. The Quality Weight will be determined in the contract between the MCO and AE. However, the minimum Quality Weight for the SDOH measure is 10%. Each measure will also be given a Reporting Score, which will be a pass/fail score (either 100% or 0%), based on timely submission of required data in accordance with agreed upon formats; there will be no partial credit for reporting. The Measure Specific Quality Score will be calculated as the product of the Quality Weight and the Reporting Score for the measure (i.e., Measure Specific Quality Score = Quality Weight x Reporting Score). The Overall AE Quality Score will be calculated as the sum of the Measure Specific Quality Scores for each measure.

Example: Overall AE Quality Score Calculation for a Specialized LTSS AE in Year 1

| Measure | Quality Weight | Reporting Score | Quality Score |
|-----------|----------------|-----------------|---------------|
| Measure 1 | 5% | 100% | 5% |
| Measure 2 | 15% | 100% | 15% |
| Measure 3 | 10% | 100% | 10% |

| | | | |
|---------------------------------|-----|------|-----|
| Measure 4 | 10% | 100% | 10% |
| Measure 5 | 20% | 0% | 0% |
| Measure 6 | 5% | 100% | 5% |
| Measure 7 (SDOH Screening) | 10% | 100% | 10% |
| Measure 8 | 5% | 0% | 0% |
| Measure 9 | 10% | 100% | 10% |
| Measure 10 | 10% | 100% | 10% |
| Overall AE Quality Score | | | 75% |

After Year 1: After Year 1, the Quality Score Determination for specialized LTSS AEs will be designed to both reward high-quality providers and create opportunities for low performers to benefit from improvement. It will also shift the emphasis from reporting to performance. The requirements will be updated in the future to describe how the Overall AE Quality Score will be calculated. However, the approach will be aligned with the comprehensive AE approach to the extent feasible and practical.

Proposed Medicaid Specialized LTSS AE Common Measure Slate

| Measure Name | Preliminary Measure Description |
|---|---|
| 1. Depression Screening and Follow-up | % of attributed population who were screened for clinical depression using a standardized tool, and received appropriate follow-up care within 30 days if positive |
| 2. Falls with Major Injury | % of attributed population experiencing one or more falls with major injury |
| 3. Advanced Care Planning | % of attributed population 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan |
| 4. Discharge to the Community from Nursing Home | % of short-stay residents attributed to the AE who were successfully discharged to the community |
| 5. ED Utilization | Rate of emergency department visits (that do not result in inpatient stays) among the attributed population |
| 6. 30-Day All-Cause Readmission | % of acute inpatient stays among the attributed population that were followed by an unplanned acute readmission for any diagnosis within 30 days |
| 7. Social Determinants of Health (SDOH) Screening | % of attributed population screened as defined per the SDOH elements in the Medicaid AE certification standards* |
| 8. Patient/Client Satisfaction | Average patient/client satisfaction rating among the attributed population |

Proposed Medicaid Specialized LTSS AE Common Measure Slate

| Measure Name | Preliminary Measure Description |
|--|---------------------------------|
| 9. Caregiver Support/ Caregiver Burden | To be determined |
| 10. Social Isolation | To be determined |

*Section 5.2.2 of the AE Certification Standards requires that each AE:

“Together with partner MCOs, develop, implement, and maintain procedures for completing an initial SDOH Care Needs Screening for Attributed Members based on a defined protocol.... The screening shall evaluate Attributed Members’ health-related social needs in order to determine the need for social service intervention. Such services shall include but not be limited to:

- Housing stabilization and support services;*
- Housing search and placement;*
- Food security;*
- Support for Attributed Members who have experience of violence.*
- Utility assistance;*
- Physical activity and nutrition;...”*

EOHHS Medicaid Infrastructure Incentive Program:

Attachment L 2: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities

Rhode Island Executive Office of Health and Human Services

| | | |
|------|--|----|
| I. | Background and Context | 3 |
| II. | Medicaid Infrastructure Incentive Program | 4 |
| III. | Determining Maximum Incentive Pool Funds | 5 |
| IV. | AE Specific Health System Transformation Project Plans | 7 |
| V. | EOHHS Priorities | 11 |
| VI. | Allowable Areas of Expenditures | 11 |
| VII. | Required Performance Areas and Milestones | 13 |

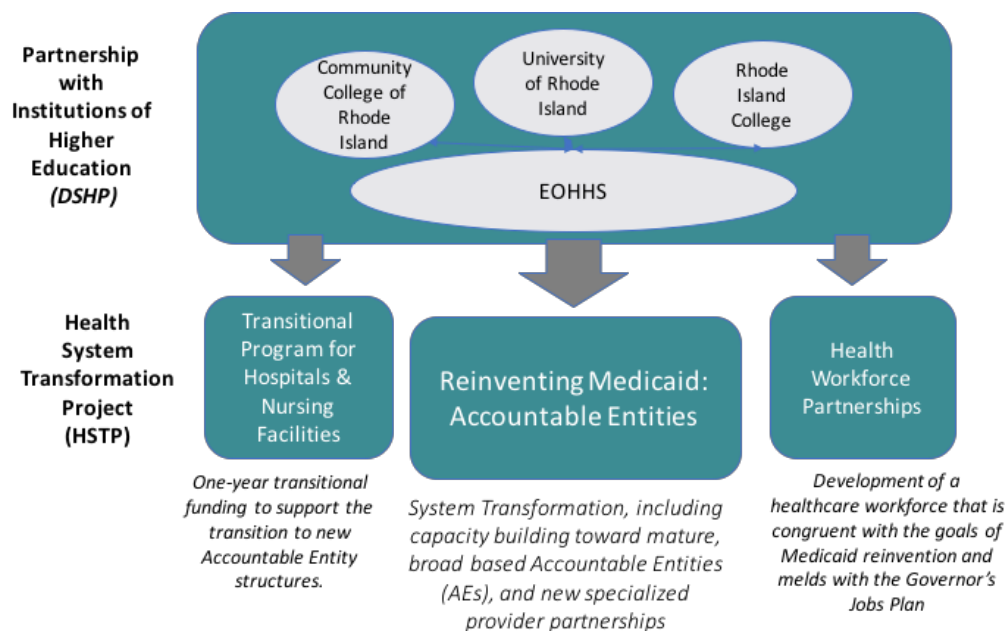
EOHHS Incentive Program Requirements

I. Background and Context

Beginning in late 2015, the Rhode Island (RI) Executive Office of Health and Human Services (EOHHS) began pursuing Medicaid waiver financing to provide support for **Accountable Entities (AEs)** by creating a pool of funds primarily focused on assisting in the design, development and implementation of the infrastructure needed to support Accountable Entities. RI submitted an application for such funding in early 2016 as an amendment to RI's current Global Medicaid 1115 Waiver. In October 2016, the Centers for Medicare & Medicaid Services (CMS) approved this waiver amendment, bringing \$129.8 million in Federal Financial Participation (FFP) to RI from November 2016 through December 2020.⁷

This funding is based on the establishment of an innovative **Health Workforce Partnership** with RI's three public institutions of higher education (IHE): University of Rhode Island (URI), Rhode Island College (RIC), and the Community College of Rhode Island (CCRI), as illustrated below.

Health System Transformation Project



The majority of the financing from this waiver amendment will be provided to AEs as incentive-based infrastructure funding via the state's managed care contracts. Other CMS supported components include:

⁷ The current Rhode Island 1115 Waiver is a 5-year demonstration, ending 12/31/2018. The STCs include DSHP funding authority through 2018, with a commitment articulated in the cover letter to extend this authority thru 2020 upon waiver renewal for a total funding opportunity of \$129 Million.

- Investments in partnerships with Institutions of Higher Education (IHEs) for statewide health workforce development and technical assistance to AEs
- One-time funding to support hospitals and nursing facilities with the transition to new AE structures⁸
- Project management support to ensure effective and timely design, development and implementation of this program
- Project demonstration pilots and project evaluation funding to support continuous program learning, advancement and refinement
- Other supporting programs, including Consumer Assistance, Wavemaker Fellowship, TB Clinic, RI Child Audiology Center, and Center for Acute Infectious Disease Epidemiology

As mentioned above, the current RI 1115 Waiver expires December 31, 2018. The Special Terms and Conditions (STCs) of the waiver amendment include expenditure authority for this program of up to \$79.9 million FFP through the end date of the current waiver.

II. Medicaid Infrastructure Incentive Program (MIIP)

Over the course of program years 1 through 4 EOHHS projects it will allocate an estimated \$95 million to the AE program through the Medicaid Infrastructure Incentive Program (MIIP), as shown below. This allocation is subject to available funds captured in accordance with CMS approved claiming protocols, and annual EOHHS review and approval. This program shall begin no earlier than January 2018 and shall be aligned with the state fiscal years as shown below. Note that Program Year 1 is an extended performance period to allow for differential start dates; as such it must begin no earlier than January 1, 2018 and no later than July 1, 2018 and must end on June 30, 2019.

| | Program Year 1 SFY 2018-19 <i>Jan 2018- Jun2019</i> | Program Year 2 SFY 2020 <i>Jul 2019- Jun 2020</i> | Program Year 3 SFY 2021 <i>Jul 2020-Jun 2021</i> | Program Year 4 SFY 2022 <i>Jul 2021-Jun 2022</i> | Total |
|---|--|--|---|---|---------------|
| Medicaid Infrastructure Incentive Program (MIIP) | \$30 M | \$30 M | \$20 M | \$15 M | \$95 M |

An AE Program Advisory Committee shall be established by EOHHS.

This committee shall be chaired by EOHHS, with a community Co-Chair and shall include representation from participating managed care organizations (MCOs), AEs, and community stakeholders and shall:

- Support the development of AE infrastructure priorities
- Help target Medicaid Infrastructure Incentive Program funds to specific priorities that maximize impact

⁸ The STCs limit this program to be one-time only and to not exceed \$20.5 million, paid on or before December 31, 2017.

- Review specific uses of funds by each AE and MCO, such that individual AE Project plans are designed and implemented to maximum effect
- Support effective program evaluation and integrated learnings
- Identify effective ways to leverage the intersection between AE project plans and workforce development partnerships

The MIIP shall consist of three core programs:

(1) Comprehensive AE Program; (2) Specialized LTSS AE Pilot Program; and (3) Specialized Pre-eligibles AE Pilot Program. EOHHS shall allocate available HSTP funds to these three programs as follows, subject to available funds and EOHHS identification of priority areas of focus and assessment of readiness. This allocation shall be revisited annually.

| AE Programs | Program Year 1 | | Full Program |
|--|----------------|---------|--------------|
| | \$ | % | |
| Comprehensive AE Program | \$21 M | 65-70%* | 60% - 70% |
| Specialized LTSS Pilot AE Program | \$9 M | 30-35%* | 25% - 35% |
| Specialized Pre-eligibles Pilot AE Program** | \$0 M | 0% | 5%-15% |
| Total Funds | \$30 M | 100% | 100% |

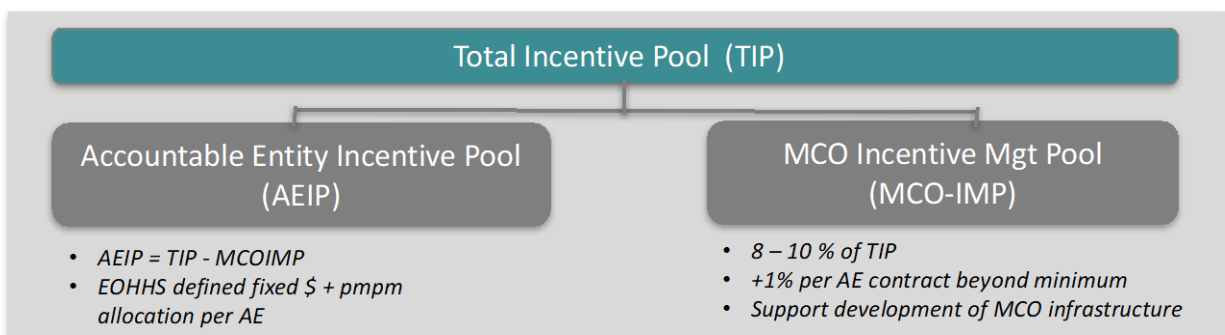
*For the purposes of illustration, PY 1 assumes a 70/30 distribution of funds between the Comprehensive AE Program and the Specialized LTSS AE Pilot Program

**Authority for this program is dependent upon CMS approval under the RI Medicaid 1115 waiver renewal, to be submitted to CMS in December 2017, effective 1/1/2019.

AEs participating in both the Comprehensive AE Program and Specialized LTSS Pilot AE Program will be eligible to receive funding from both incentive pools.

III. Determining Maximum Incentive Pool Funds

The MIIP shall include three dimensions:



Maximum Total Incentive Pool (TIP)

The maximum Total Incentive Pool (TIP) is provided in the table below. This TIP shall be

allocated to each MCO by EOHHS with consideration of the MCO share of AE attributed lives in accordance with EOHHS defined attribution guidelines and associated reports.

1. MCO Incentive Management Pool (MCO-IMP)

Assuming satisfactory MCO performance, the MCO Incentive Management Pool that can be earned by the MCO shall be eight percent (8%) of the Total Incentive Pool. However, to the degree that the MCO has more than the minimally required number of contracts with AEs, the maximum MCO-IMP shall be increased by one percent for each AE contract to a maximum of ten percent (10%). These funds are intended for use toward advancing program success, including program administration and oversight, assisting with the development of the necessary infrastructure to support a new business model, and establishing shared responsibilities, information requirements and reporting between EOHHS, the MCO and the Accountable Entities.

2. Accountable Entity Incentive Pool (AEIP)

The Accountable Entity Incentive Pool shall equal the Total Incentive Pool minus the

| MIIP Funds Program Year 1 <i>Jan 2018-Jun2019</i> | Accountable Entity Incentive Pool (AEIP) | MCO Incentive Management Pool (MCO-IMP) | Total Incentive Pool (TIP) |
|---|---|---|-------------------------------|
| Comprehensive AE Program | \$18.9 M | \$ 2.1 M | \$21.0 M |
| Specialized LTSS Pilot Program | \$8.1 M | \$0.9 M | \$9.0 M |
| Total Funds | \$27.0 M | \$3.0 M | \$30.0 M |
| % Total | 90% | 10% | 100% |

maximum MCO Incentive Program Management Pool (AEIP = TIP – MCO-IMP). This shall determine the total annual amount and schedule of incentive payments each participating AE may be eligible to receive from the Accountable Entity Incentive Pool.

Consistent with this structure, Program Year 1 MIIP funds shall be allocated as follows, subject to available funds:

AE-Specific Incentive Pools

Certified AEs in qualified Alternative Payment Methodology (APM) contracts consistent with EOHHS requirements must be eligible to participate in the Medicaid Infrastructure Incentive Program. Each MCO must create an AE-Specific Incentive Pool for each Certified AE to establish the total incentive dollars that may be earned by each AE during the period.

For Program Year 1, this AE Specific Incentive Pool shall be calculated by the MCOs as follows:

- **Comprehensive AE- Specific Incentive Pools** shall be the sum of two pieces (a) an incentive pool amount derived from a per member per month (PMPM) times the number of attributed lives in accordance with the following formula, plus (b) a fixed-amount base incentive pool per AE.

| | | | |
|----------------------------|---------------------------|-------------|---|
| Estimated PMPM* | x Attributed Lives | x 12 | + Estimated Base Incentive Pool* |
|----------------------------|---------------------------|-------------|---|

| | | | |
|--------|---|---------------------------|----------------------------------|
| \$8.00 | At the start of each Program Year in accordance with EOHHS defined requirements | Translate to Member Month | \$750,000 Fixed Amount per AE |
|--------|---|---------------------------|----------------------------------|

*Note that the PMPM and base incentive pool are dependent upon the number of Certified AEs and the total attributed lives in the AE program. As such, these amounts are only estimates, and shall be finalized by EOHHS within 30 days of AE Certification.

- **The Specialized LTSS Pilot AE-Specific Incentive Pool** shall be determined on a per AE basis, in accordance with the formula below. The pool funding depends upon the number of Certified participating LTSS Pilot AEs as follows. This pool structure shall be finalized by EOHHS within 30 days of AE Certification. If there are fewer than four (4) certified AEs, the funds per AE remain unchanged, and any unallocated funds will be retained for future Specialized AE program use.

| # Certified LTSS AEs | Program Year 1 Total \$ Per Certified LTSS AE |
|----------------------|---|
| 2 | \$2.0 M |
| 3 | \$2.0 M |
| 4 | \$2.0 M |
| 5 | \$1.6 M |
| 6 | \$1.4 M |

Note that the Specialized LTSS Program is a pilot, and as such is intended to both enhance core capabilities and provide a basis for testing the validity of the APM model. As such, 20% of the AE Specific Incentive Pool shall be set aside to support the potential shared savings associated with each AE's Total Cost of Care target, inclusive of the required quality multiplier, in accordance with state defined APM requirements, as specified in Section F of this document.

IV. AE Specific Health System Transformation Project Plans (HSTP Plans)

Under the terms of Rhode Island's agreement with the federal government, this is not a grant program. AEs must earn payments by meeting metrics defined by EOHHS and its managed care partners, and approved by CMS to secure full funding.

Certified AEs and MCOs must jointly develop individual Health System Transformation Project Plans (HSTP Plans) that identify clear project objectives and specify the activities and timelines for achieving the proposed objectives. Actual AEIP incentive payment amounts to AEs will be based on demonstrated AE performance, accordingly, incentive payments actually earned by the AE may be less than the amount they are potentially eligible to earn. MCOs shall not be entitled to any portion of funds from the Accountable Entity Incentive Pool that are not earned by the AE. Any monies not remitted to an AE from the Accountable Entity Incentive Pool must be returned to EOHHS.

Specifications Regarding Allowable AE Specific HSTP Project Plans

Approvable HSTP Project Plans must specify:

- **Core Goals**

Approvable project plans must demonstrate how the project will advance the core goals of the Health System Transformation Project and identify clear objectives and steps for achieving the goals.

- **Data Driven Identification of Shared MCO/AE Priorities**

Plan must identify a set of shared MCO/AE priorities based on population specific analysis of service needs, capabilities and key performance indicators. To inform this work the MCO shall provide a population specific analysis of the AE's attributed population. The data driven assessment may provide a basis for risk segmentation of the population served by the AE that can help guide project plans. Data analyses may identify patterns of gaps in coordinated care for population subgroups such as adults with co-occurring medical and behavioral health needs and/or may identify avoidable inpatient or emergency department utilization in specific geographic areas. Project plans then focus on tangible projects within the certification domain areas, such as IT capability to identify and track needs or strengthen targeted care management or patient engagement processes. This provides for the linkage between recognized areas of need/opportunity and developmental tasks. Shared priorities must be developed through a joint MCO/AE working group that includes clinical leadership from both the MCO and the AE⁹ and using a data driven approach to consider issues such as:

- EOHHS priorities, as defined in Section D
- Data driven assessment of the specific needs of the population served by the AE
- The service profile of the AE (current and proposed)
- Specific gaps in AE capacities and capabilities as defined in the AE Certification Application
- Key Performance gaps, in quality and outcomes, relative to the populations served
- Areas of potential enhancement of workforce skill sets to better enable system transformation

- **AE Specific Core Projects: Workplan and Budget**

The AE must develop a multi-year workplan and budget to address these priorities over the course of the program (Program Year 1-4). A more detailed workplan and budget must be developed for Program Year 1 that identifies a requested set of core projects in the pertinent Domains needed to address the Shared MCO/AE Priorities. Workplan objectives for Program Years 2-4 would be at a higher level with increased refinement for the subsequent periods. To avoid duplication of funds, each core project must be MCO specific, and must specify the requested **Areas of Expenditure consistent with requirements in Section E.**

- **Performance Areas and Milestones**

Approvable project plans must set milestones and deadlines for the meeting of metrics associated with each of the Core Projects to ensure timely performance, **consistent with**

⁹ Note: Membership in this Working Group shall be specified in the AE application, as a condition of certification.

requirements in Section F.

MCO Review Committee Guidelines for Evaluation

The MCO shall convene a review committee to evaluate the Detailed Workplan and Budget described above. EOHHS shall have a designee that participates on the MCO evaluation committee to ensure the state's engagement in the evaluation of the project plan and associated recommendations for approval or disapproval. The MCO Review Committee, in accordance with EOHHS guidelines, shall determine whether:

- **Core Projects as submitted are eligible for award**
Eligible core projects will include a workplan that clearly addresses EOHHS priority areas and includes the types of activities targeted for funds.
- **Core Projects that merit Incentive Funding**
Projects must show appropriateness for this program by including the following:
 - Clear statement of understanding of the intent of incentive dollars
 - Rationale for this incentive opportunity, including a clear description of the objective for the project and how achieving that objective will promote health system transformation for that AE
 - Confirmation that the project does not supplant funding from any other source and that project funding is non-duplicative of any submissions made to another MCO
 - The inclusion of a gap analysis and an explanation of how the workplan and-associated incentive plan and budget address these gaps
 - Clear interim and final project milestones and projected impacts, as well as criteria for recognizing achievement of these milestones and quantifying these impacts
- **Incentive Funding request is reasonable and appropriate**
The funding request must be reasonable for the project identified, with funds clearly dedicated to this project. The level and apportionment of the incentive funding request must be commensurate with value and level of effort required.

At the discretion of the EOHHS designee, the designee may refer the proposed project for EOHHS review and approval prior to development of the subcontract between the MCO and the AE.

Development of the proposed project plan and its acceptance by the MCO Review Committee shall be considered a Performance Milestone of the HSTP Program, as specified in Section F.

Required Structure for Implementation

The Incentive Funding Request **must be awarded to the AE via a Contract Amendment** between the MCO and the AE. The Contract Amendment shall:

- Be subject to EOHHS review and approval
- Incorporate the central elements of the approved AE submission, including:
 - Stipulation of program objective
 - Scope of activity to achieve (may be incorporated via reference to separate project plan)
 - Performance schedule and performance metrics

- Payment terms – basis for earning incentive payment(s) commensurate with the value and level of effort required.
- Define a review process and timeline to evaluate progress and determine whether AE performance warrants incentive payments. The MCO must certify that an AE has met its approved metrics as a condition for the release of associated Health System Transformation Project funds to the AE.
- Minimally require that AEs submit semi-annual reports to the MCO using a standard reporting form to document progress in meeting quality and cost objectives that would entitle the AE to qualify to receive Health System Transformation Project payments; such reports will be provided to EOHHS by the MCO.¹⁰
- Stipulate that the AE earn payments through demonstrated performance. The AE's failure to fully meet a performance metric under its AE Health System Transformation Project Plan within the timeframe specified will result in forfeiture of the associated incentive payment (i.e. there will be no payment for partial fulfillment).
- Provide a process by which an AE that fails to meet a performance metric in a timely manner (thereby forfeiting the associated Health System Transformation Project Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.

Reconciliation

In advance of the MCOs payments to AEs, the MCO shall receive payment from EOHHS in the amount and schedule agreed upon with EOHHS. MCOs shall make associated payments to AEs within thirty (30) calendar days of receipt of payment. The MCO will maintain a report of funds received and disbursed by transaction in a format and in the level of detail specified by EOHHS. Within fifteen days after the end of each calendar quarter, the MCO will provide the report to EOHHS for reconciliation. The MCO will work with EOHHS to resolve any discrepancies within fifteen calendar days of notification of such discrepancy. Any Incentive Program funds that are not earned by EOHHS Certified AEs as planned will be returned to EOHHS within thirty days of such request by EOHHS. An AE's failure to fully meet a performance metric within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment). An AE that fails to meet a performance metric in a timely fashion can earn the incentive payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.

Project Plan Modifications

Subcontracts between the AE and the MCO associated with AE-specific HSTP Project Plans may only be modified with state approval. EOHHS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.

¹⁰ Reporting templates will be developed in partnership with EOHHS

V. EOHHS Priorities

Each MCO's AE Incentive Pool budget and actual spending must align with the priorities of EOHHS as developed with the support of the Advisory Committee and shown below. Note: This is a draft set of priorities – a final set of priorities shall be reviewed by the Advisory Committee and confirmed by EOHHS.

| Program | Priorities |
|-----------------------------------|--|
| Comprehensive AEs | <ul style="list-style-type: none">• Integration and innovation in behavioral health care• Integration and innovation in SUD treatment• Integration and intervention in social determinants, including cross system impacts |
| Specialized Pilot LTSS AEs | <ul style="list-style-type: none">• Developing programs and care coordination processes to enable people to reside safely in a community setting and to promote timely care transitions and reduced institutional/ED utilization• Home and Community based Behavioral Health capacity development for specialized adult day care, home care, and alternative living arrangements with capacity to serve members with behavioral health and/or dementia/Alzheimer's related service needs• Repurposing skilled nursing capacity for acute psychiatric transitions and/or adult day capacity |

Consistent with these priorities and the requirements of the AE Certification Standards, Comprehensive AEs shall be required to demonstrate that at least 10% of Program Year 1 Incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants.

VI. Allowable Areas of Expenditure

Allowable uses of funds include the following three core areas and eight domains. Costs must be reasonable for services rendered.

EOHHS anticipates that some AEs incentives in Program Year 1 may be weighted toward development in core readiness domains 1-3 as set forth in the certification standards, as AEs build the capacity and tools required for effective system transformation. However, over time the allowable areas of expenditure will be required to shift toward system transformation capacities (domains 4-8). As such, in Program Year 1, allowable Readiness Expenditures (Category A, Domains 1 through 3 below), are limited as follows:

- Comprehensive AEs may devote no more than 30% of the total HSTP incentive pool to projects in the in the readiness category (Domains 1-3)
- Specialized AEs may devote no more than 60% of the total HSTP incentive pool to projects in the readiness category (Domains 1-3)

| | Domains | Allowable Uses of Funds |
|--------------------------|--|--|
| A. Readiness | 1. Breadth and Characteristics of Participating Providers | <ul style="list-style-type: none"> Building provider base, population specific provider capacity, interdisciplinary partnerships, developing a defined affiliation with community based organizations (CBOs) Developing full continuum of services, Integrated PH/BH, Social determinants |
| | 2. Corporate Structure and Governance | <ul style="list-style-type: none"> Establishing a distinct corporation, with interdisciplinary partners joined in a common enterprise |
| | 3. Leadership and Management | <ul style="list-style-type: none"> Establishing an initial management structure/staffing profile Developing ability to manage care under Total Cost of Care (TCOC) arrangement with increased risk and responsibility |
| B. IT Infrastructure* | 4. Data Analytic Capacity and Deployment | <ul style="list-style-type: none"> Building core infrastructure: EHR capacity, patient registries, Current Care Provider/care managers' access to information: Lookup capability, medication lists, shared messaging, referral management, alerts Patient portal Analytics for population segmentation, risk stratification, predictive modeling Integrating analytic work with clinical care: Clinical decision support tools, early warning systems, dashboard, alerts Staff development and training – individual/team drill downs re: conformance with accepted standards of care, deviations from best practice |
| C. System Transformation | 5. Commitment to Population Health and System Transformation | <ul style="list-style-type: none"> Developing an integrated strategic plan for population health that is population based, data driven, evidence based, client centered, recognizes Social Determinants of Health, team based, integrates BH, IDs risk factors Healthcare workforce planning and programming |
| | 6. Integrated Care Management | <ul style="list-style-type: none"> Systematic process to ID patients for care management Defined Coordinated Care Team, with specialized expertise and staff for distinct subpopulations Individualized person-centered care plan for high risk members |
| | 7. Member Engagement and Access | <ul style="list-style-type: none"> Defined strategies to maximize effective member contact and engagement Use of new technologies for member engagement, health status monitoring and health promotion |
| | 8. Quality Management | <ul style="list-style-type: none"> Defined quality assessment & improvement plan, overseen by quality committee |

* The state may make direct investments in certain technology to support provider to provider EHR communication, such as dashboards and alerts. This investment would be made directly by the state with vendor(s) which would have the capacity and expertise to create and implement this technology in AEs statewide. This may be done in certain technology areas where direct purchasing by the state would result in significant efficiencies and cost savings. The products and tools resulting from this direct state technology investment would be made available to all AEs at no upfront charge. AEs would have the choice to either utilize the statewide tool at no charge or pay for their own tool. In this case, DSRIP funds would not be available for the AE to separately purchase such a tool.

Note that the allowable uses of funds specified above may not include any of the following expenditures:

- Alcoholic beverages
- Capital expenditures (unless approved in advance by EOHHS)
- Debt restructuring and bad debt
- Defense and prosecution of criminal and civil proceedings, and claims
- Donations and contributions
- Entertainment
- Fines and penalties
- Fund raising and investment management costs
- Goods or services for personal use
- Idle facilities and idle capacity
- Insurance and indemnification
- Interest expense
- Lobbying
- Marketing/member communication expense, unless approved in advance by EOHHS
- Memberships and subscription costs
- Patent costs

These non-allowable expenditures have been developed in alignment with Section 2 CFR 200 which outlines Financial Management and Internal Control Requirements for receipt, tracking and use of federal funds by non-Federal awardees, and shall be updated by EOHHS as appropriate.

VII. Required Performance Areas and Milestones

AEs must develop AE Specific Health System Transformation Project Plans. These plans shall specify the performance that would qualify an AE to earn incentive payments. The execution of an EOHHS qualified APM contract with the MCO shall be considered the first Performance Milestone of the HSTP Program, as shown below.

Earned funds shall be awarded by the MCO to the AE in accordance with the distribution by performance area defined in the AE specific Health System Transformation Plan, consistent with the requirements defined below:

| Performance Area | Minimum Milestones | Program Year 1 |
|---------------------------------|---|----------------|
| Developmental Milestones | <ul style="list-style-type: none"> • Execution of an EOHHS qualified APM contract with the MCO, including performance milestones agreed upon by both parties • Detailed Health System Transformation Project Plan, including a specified set of Core Projects, and a proposed Infrastructure Development Budget by Project and Domain in accordance with state specified template • Quarterly Progress and Financial Reports in accordance with state defined template | 75% |

| | | |
|---------------------------------------|---|-------------|
| | <ul style="list-style-type: none"> Developmental milestones MCO/AE Defined (at least 3 unique developmental milestones per Core Project per year) | |
| Value based purchasing metrics | <ul style="list-style-type: none"> Demonstrated APM Progression, development of defined modeling capabilities to manage care under a TCOC approach Marginal Risk Requirements Minimum required share of marginal risk for which the AE is liable, in accordance with EOHHS define APM guidelines | 5% |
| Outcome Metrics* | <p>Comprehensive</p> <ul style="list-style-type: none"> Preventable Admissions Readmissions Avoidable ED Use MCO/AE Specific Performance Targets <p>Specialized</p> <ul style="list-style-type: none"> Total Cost of Care, inclusive of quality multiplier, in accordance with state defined APM requirements Preventable Admissions Readmissions Completion of Advanced Directives | 20% |
| Total | | 100% |

*Note: For Program Year 1, at least 50% of the performance goals on outcome metrics shall be based on reporting only (for both Comprehensive and Specialized LTSS AEs).

The early milestones are intended to allow AEs to develop the foundational tools and human resources that will enable AEs to build core competencies and capacity. In accordance with EOHHS' agreement with CMS, participating AEs must fully meet milestones established in the AE specific Health System Transformation Project prior to payment. EOHHS recognizes the financial constraints of many participating AEs and that timely payment for the achievement of early milestones will be critical to program success.

Rhode Island Medicaid Accountable Entity Program

Attachment M: Accountable Entity Attribution Requirements

Rhode Island Executive Office of Health and Human Services

Table of Contents

| | |
|---|----------|
| J. Attribution Overview | 3 |
| 1.1 Attribution Methodology Goals | |
| K. Background | 3 |
| L. Comprehensive AE Attribution | 4 |
| 3.1. Population Eligible for Attribution to a Comprehensive AE | |
| 3.2. Certified Comprehensive AE-Identified Providers | |
| 3.3 Hierarchy of Attribution for Comprehensive AEs | |
| M. Specialized LTSS AE Attribution | 7 |
| 4.1. Population Eligible for Attribution to a Specialized LTSS AE | |
| 4.2. Certified Specialized LTSS AE -Identified Providers | |
| 4.3 Attribution Methodology for Specialized LTSS AEs | |

Attachments

- Attachment A: Excerpts from EOHHS-MCO Contracts Regarding Assignment of Primary Care Providers
- Attachment B: Qualifying Primary Care Services as Identified by CPT Codes

1. Attribution Overview

Attribution is the process of defining the population on which total costs are calculated for the purposes of identifying savings under a shared savings or risk contract. Effective attribution provides an incentive for providers and Accountable Entities (AEs) to invest in care management and other appropriate services to keep their attributed population well, with the intention of earning savings by lowering total costs and ensuring high quality care. Attribution does not affect consumers' freedom to choose or change their providers at any point in their care. However, AEs are expected to have continuing responsibility for the care and outcomes of their attributed members on an on-going basis, unless there is a compelling reason for that responsibility to change.

1.1. Attribution Methodology Goals

The attribution method, to be applied across all Managed Care Organizations (MCOs) and AEs, is intended to:

- Allow providers who have identified responsibility for member costs to earn savings by reducing those costs in the future;
- Allow Integrated Health Homes (IHH) to assume this responsibility for members with an approved IHH diagnosis and to allow Long-Term Services and Supports (LTSS) providers to assume this responsibility for members receiving certain long-term care services; and
- Be transparent and understandable to all program participants.

2. Background

Attribution is the foundation of the linkage of the member to an AE. Attribution identifies the population that the AE is accountable for in the overall AE program. This includes accountability of the AE for the health and health care for that person as represented in access, quality, and total cost of care metrics. The program intent is to recognize and strengthen an existing relationship of the member with the AE and its clinical programs. For comprehensive AEs, it is also to establish the basis for such relationship for members who do not have an established relationship with a primary care provider (PCP).

The foundations for attribution are:

- A population of Medicaid beneficiaries eligible for attribution.
- A defined provider roster of the certified AE to which members may be attributed.
 - Each certified AE will have a defined roster of providers that will qualify the AE for attributed members.
 - For comprehensive AEs, the provider roster will consist of:
 - IHH providers as licensed by the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) if an IHH is a recognized Partner Provider or Affiliate Provider in the AE; and
 - PCPs, as described in Section 3.2, at a Partner Provider or Affiliate Provider in the AE.
 - For specialized LTSS AEs, the provider roster will consist of agencies licensed by the Rhode Island Department of Health to provide one or more of the attributable services listed in Table A in Section 4.2.
- A clear methodology for attribution of eligible members to a certified AE.

- For comprehensive AEs, this includes:
 - MCO algorithm for initial PCP assignment and attribution; and
 - Methodology for updated attribution based on utilization of identified primary care services provided by an eligible PCP.
- For specialized LTSS AEs, this includes:
 - Monthly attribution based on service authorizations; and
 - AE validation of the attribution.

These attribution requirements set forth the basis for:

- (a) Identifying the specific AE provider roster eligible for attribution; and
- (b) The basis for attribution of members to the AE.

An attribution-eligible provider can only participate in one comprehensive AE at a time for the purposes of attribution. An attribution-eligible provider can only participate in one specialized LTSS AE at a time for the purposes of attribution.

A member can only be attributed to a single comprehensive AE at a time. A member can only be attributed to a single specialized LTSS AE at a time. However, a member who meets the requirements for attribution to both a comprehensive AE and a specialized LTSS AE at the same time will be attributed to both AEs.

3. Comprehensive AE Attribution

3.1. Population Eligible for Attribution to a Comprehensive AE

The population eligible for attribution to a comprehensive AE consists of all Medicaid-only beneficiaries enrolled in managed care. Rhody Health Options (RHO) members shall be included in AE attribution if the RHO member is receiving Medicaid benefits only (not Medicare). RHO and Medicare-Medicaid Plan members who have both Medicare and Medicaid coverage are not eligible for attribution to a comprehensive AE.

3.2. Certified Comprehensive AE-Identified Providers

Attribution of members to comprehensive AE's will be based on the defined roster of providers included within the structure of the AE. For IHHs, recognition by BHDDH as a qualified IHH will be the basis for attributing members to the AE.

For primary care, each AE shall have a defined roster of PCPs. A PCP is defined as the individual plan physician or team selected by or assigned to the member to provide and coordinate all the member's health care needs and to initiate and monitor referrals for specialized services when required. PCPs are Medical Doctors or Doctors of Osteopathy in the following specialties: family and general practice, pediatrics, internal medicine, or geriatrics who have a demonstrated clinical relationship as the principal coordinator of care for children or adults and who have contracted with the MCO to undertake the responsibilities of serving as a PCP as stipulated in the MCO's primary care agreements. PCPs shall also meet the credentialing criteria established by the MCO and approved by EOHHS. In addition to physicians, the PCP may be a nurse practitioner, physician assistant, or a Federally Qualified Health Center (FQHC). Clinicians included in the provider roster shall be identified by TIN and by NPI.

AEs that include FQHCs are required to provide, through an attestation, a list of the clinicians' NPIs that provide direct patient primary care services in an FQHC. This attestation will be part of the application process for all comprehensive AEs and shall be updated minimally on a quarterly basis.

3.3. Hierarchy of Attribution for Comprehensive AEs

Members will be attributed to a comprehensive AE as follows:

Assignment Hierarchy

1st: IHH Assignment

If a member is assigned to an IHH, and that IHH is a part of a comprehensive AE, then the member is attributed to that AE. IHH assignment is based on monthly roster produced by BHDDH and provided to the MCO. IHH assignment is based on two sequential steps.

- Step 1: Assignment to the AE based on assignment to IHH, as determined by BHDDH. Note that IHH based attribution is inclusive of persons utilizing ACT services.
- Step 2: Quarterly Updates to that assignment
 - A member attributed to an AE based on assignment to an IHH shall continue to be attributed to that AE for one year following IHH discharge unless:
 - The member is assigned by BHDDH to a different IHH;
 - The member requests that the MCO change his or her PCP to one that is participating in an AE.

2nd: PCP Assignment by the MCO

PCP assignment by the MCO will be based on two sequential steps:

- Step 1: PCP assignment by the MCO at the point of entry by the member into the MCO
- Step 2: Quarterly updates to that assignment based on:
 - Member requests to the MCO to change his or her PCP; and
 - Analyses of actual patterns of utilization that demonstrate member use of a different PCP than the one assigned by the MCO.

Step 1: Assignment by the MCO at the point of entry into the MCO

A fundamental requirement of EOHHS' contract with the MCO is that, to ensure the member's timely ability to meaningfully access health care services, the MCO must ensure that the member has an identified PCP. The challenge for the MCO is that the MCO has very limited information about whether a new member has an established relationship with, or preference for assignment to, a specific PCP. The MCO contract sets forth certain requirements on procedures for PCP assignment that are intended to promote an appropriate PCP assignment for the member (see Attachment A). A member may change his or her PCP assignment at any time, and MCOs routinely inform members of their right to change PCPs at any time upon request.

Step 2: Quarterly updates to PCP assignment and attribution based on:

- Member requests that the MCO change the PCP to one that is not participating in the AE
- Analyses of actual patterns of utilization that demonstrate member use of a different PCP than the one assigned by the MCO

Despite best efforts by MCOs at initial PCP assignment and the ready accommodation of member requests for a change in the assigned PCP, there will be some differences between the assigned PCP of record and the actual pattern of primary care utilization by the member. MCOs will update attribution on a quarterly basis based on retrospective analysis of actual patterns of primary care use.

EOHHS establishes a stepwise attribution algorithm hierarchy to be used in updating the attribution. Requirements for PCP related attribution are as follows:

1. Attribution to the AE will be based on PCP assignment of record within the MCO. PCP assignment of record shall be based on:
 - 1.1. Original assignment by the MCO
 - 1.2. Change of PCP assignment of record based on a member's request to change PCP
 - 1.3. Change of PCP assignment of record based on analysis of the member's actual primary care utilization
2. Attribution based on actual primary care utilization:
 - 2.1. Not later than thirty days after the close of each calendar quarter, claims for eligible members shall be analyzed to identify the presence of visits to a PCP with qualifying primary care services as identified by CPT codes and/or FQHC encounter codes for the preceding twelve-month period (see Attachment B for qualifying CPT codes). The provider specialty must be a PCP eligible for attribution.
 - 2.2. Attribution will be at the AE level based on aggregating utilization across all TINs that are part of the AE roster of attributable providers. Multiple visits to PCPs within an AE will be aggregated to that AE.
 - 2.3. For attributed members that have received all their qualified primary care services from a qualified provider within the AE, the PCP assignment will be unchanged from the PCP assignment as recognized by the MCO.
 - 2.4. For beneficiaries that have not received any primary care services during the period, the attribution will continue to be based on the MCO's PCP assignment.
 - 2.5. The MCO will identify beneficiaries who have had at least two visits to a PCP with qualifying primary care services as described in 2.1 and received at least one primary care service from a PCP who is not a participating provider in the AE.
 - 2.5.1. For those beneficiaries, the attribution hierarchy will then be as follows:
 - 2.5.1.1. Where there are two or more visits to providers, attribution is based on a plurality of primary care visits, with attribution based on the AE providers or on the non-AE PCP providing the highest number of visits. If the AE's providers are tied for the highest number of visits, attribution will remain with the AE.

To be enrolled in Medicaid managed care, an individual must be Medicaid eligible. MCOs shall be required monthly to provide contracted AEs with electronic lists of attributed members, inclusive of identification of additions and deletions. These lists will be updated to reflect changes including new members, persons who have lost Medicaid eligibility, persons who have requested a PCP not included in the AE, and the results of quarterly updates to PCP assignment and attribution.

4. Specialized LTSS AE Attribution

4.1. Population Eligible for Attribution to a Specialized LTSS AE

The population eligible for attribution to a specialized LTSS AE consists of all adult (age 21 and older) Medicaid-only and Medicare-Medicaid beneficiaries enrolled in managed care, including the Medicare-Medicaid Plan, or receiving Medicaid benefits through Medicaid fee-for-service. Children under age 21 are not currently eligible for attribution to a specialized LTSS AE. An LTSS eligibility determination in the State Medicaid eligibility system is not required for attribution.

Note that the specialized LTSS AE program is a pilot program and as such, EOHHS intends to engage in a systematic review of the guidelines established below as the program develops.

4.2. Certified Specialized LTSS AE-Identified Providers

Attribution of members to a specialized LTSS AE will be based on the defined roster of providers included within the structure of the AE. Each AE shall have a defined roster of providers. For specialized LTSS AEs, the provider roster will consist of agencies licensed by the Rhode Island Department of Health to provide one or more of the attributable services listed in Table A. Actual attribution will depend on the composition of providers in the specialized LTSS AE.

Table A: Specialized LTSS AE Attributable Services and Billing Codes

| Service Type | Attributable Services |
|--|--|
| Home and Community Based Services | <ul style="list-style-type: none"> • Home Care Services, including: <ul style="list-style-type: none"> ○ Homemaker Services <ul style="list-style-type: none"> ▪ S5130 ○ Home Health Aide/CNA/Attendant Care Services <ul style="list-style-type: none"> ▪ S5125 ▪ S9122 ▪ T1004 • Adult Day Health Services <ul style="list-style-type: none"> ○ S5100-S5109 • Assisted Living <ul style="list-style-type: none"> ○ T2031 • Supported Living Arrangements/Shared Living <ul style="list-style-type: none"> ○ S5136 ○ T2025 ○ T2028 |
| Institutional Services | <ul style="list-style-type: none"> • Long-Stay/Custodial and Skilled Nursing Facility Care |

Services managed by BHDDH for people with intellectual and developmental disabilities are excluded as attributable services.

4.3. Attribution Methodology for Specialized LTSS AEs

Attribution to a specialized LTSS AE will be based on two sequential steps each month:

- Step 1: Monthly attribution based on service authorizations; and
- Step 2: Validation of the attribution.

Step 1: Monthly attribution based on service authorizations

When a Medicaid beneficiary in Medicaid managed care or Medicaid fee-for-service receives any of the attributable services in Table A, a service authorization or approval is entered into one or more information systems used by the MCO or the State to manage beneficiaries' services. For specialized LTSS AE attribution, this authorization and approval information will be used to link a beneficiary to a specific provider and will be used to attribute beneficiaries to a specialized LTSS AE monthly using the attribution requirements described below.

The initial attribution to the AE will be based on any active authorization or approval, as of the first day of the month, for a service listed in Table A with any provider on the AE roster. Monthly, the initial attribution will be updated to reflect new authorizations for services, changes in authorization, and changes in Medicaid eligibility.

These updates will include people newly attributed to an AE, people who are removed from AE attribution, and people who move from the attribution for one AE to the attribution for another AE.

AEs are expected to have continuing responsibility for the care and outcomes of their patients on an on-going basis, unless there is a compelling reason for that responsibility to change.

Once attributed to a specialized LTSS AE, a Medicaid beneficiary will continue to be attributed monthly to the specialized LTSS AE for at least 9 months after the beneficiary stops receiving services from a provider in the specialized LTSS AE, unless there is a new authorization for a different attributable service with a provider in a different specialized LTSS AE. When this occurs, the attribution will be updated to the specialized LTSS AE that includes the provider with the new authorization after 90 days. If the new authorization begins more than 90 days after the terminated authorization ends, the attribution will be updated at the next monthly attribution update. Examples of attribution scenarios are provided for illustrative purposes in Table B.

Table B: Illustrative Examples of Specialized LTSS AE Attribution Scenarios

| Scenario | Impact on Attribution | Example |
|--|--|---|
| An authorization for an attributable service with a provider in an AE is terminated. Within three months of the authorization terminating, a new authorization for an attributable service with a provider in a different AE becomes effective. | The beneficiary's will remain attributed to the AE that includes the provider with the terminated authorization for 90 days after the authorization is terminated. The attribution will be updated to the AE that includes the provider with the new authorization during the next monthly update that occurs 90 days after the first authorization is terminated. | Mary is receiving Home Care Services from a provider in AE 1. Her Home Care authorization is terminated when she has a Long-Stay/Custodial Nursing Facility admission on January 15 and a new authorization for a Long-Stay/Custodial Nursing Facility Care with a provider in AE 2 becomes effective. She remains in the facility for over 90 days. Mary's attribution is updated from AE 1 to AE 2 in the attribution update that is effective May 1. |
| An authorization for an attributable service with a provider in an AE is terminated. More than three months after the authorization terminated, a new authorization for an attributable service with a provider in a different AE becomes effective. | The attribution will be updated to the AE that includes the new provider during the next monthly update that occurs after the new authorization is effective. | Sue is receiving Adult Day Health Services from a provider in AE 3. She stops going to this Adult Day Health Services provider on March 12. She begins going to another Adult Day Health Services Provider, which is part of AE 4, on August 16. Sue remains attributed to AE 3 until August 31. Her attribution is updated from AE 3 to AE 4 in the attribution update that is effective September 1. |
| An authorization for an attributable service with a provider in an AE is terminated. There is no other active authorization for an attributable service for more than 9 months. | The beneficiary will remain attributed to the AE for 9 months after the authorization is terminated. The attribution will be updated to remove this person in the next monthly update that occurs 9 months after the authorization is terminated. | Eduardo is receiving Home Care Services from a provider in AE X. His Home Care authorization is terminated on April 20, 2018, and no other authorization for an attributable service is active for the next 9 months. Eduardo remains attributed to AE X for 9 months after April 20, 2018. He is removed from AE X's attribution in the attribution update that is effective May 1, 2019. |

NOTE: Table B provides examples of some specialized LTSS AE attribution scenarios for illustrative purposes only. It is not intended to address all potential attribution scenarios.

Attribution to a specialized LTSS AE will be unaffected by changes in Medicaid managed care enrollment (e.g., moved from Medicaid fee-for-service to Rhody Health Options, moved from Rhody Health Options to the Medicare-Medicaid Plan), as long as the AE is contracted with the MCO/payer the beneficiary is enrolled in.

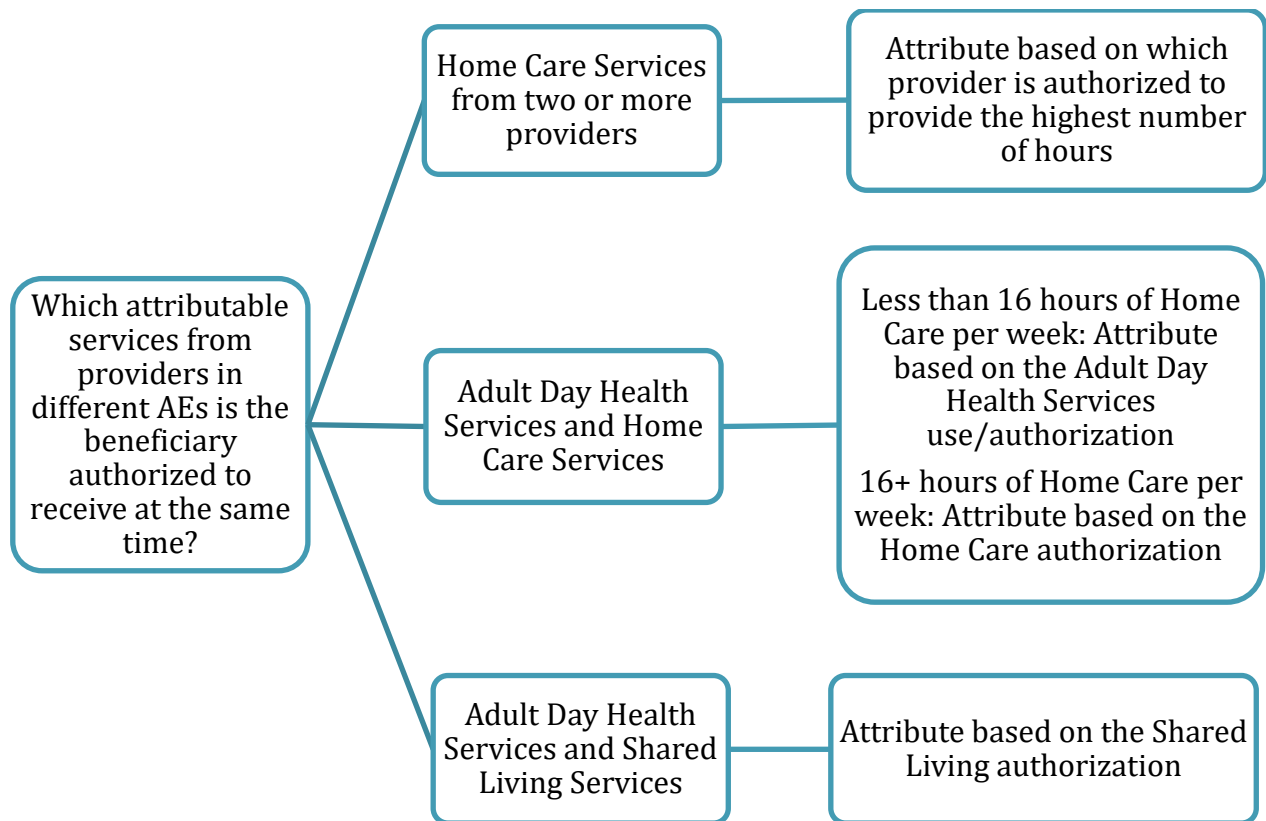
If a beneficiary has active authorizations for services from providers in different AEs at the same time, the hierarchy for attribution will be as follows:

1. If a beneficiary is authorized to receive Home Care Services from more than one agency, attribution will be to the AE that includes the provider authorized for the highest number of service hours. If there is a tie for the provider with the highest number of hours, attribution will be based on the provider that historically has provided the highest number of hours.
2. If a beneficiary is authorized to receive Adult Day Health Services and Home Care Services, attribution will be to the AE that includes the Adult Day Health provider if the beneficiary is receiving fewer than sixteen (16) hours per week of Home Care Services from a single provider. Otherwise, attribution will be based on the AE that includes the provider with the highest number of Home Care Services.
3. If an adult beneficiary is authorized to receive Adult Day Health Services and Shared Living Services, attribution will be to the AE that includes the Shared Living provider.

These guidelines apply to both the initial attribution and the monthly updates. Due to Medicaid rules related to service use, beneficiaries should not receive Home Care Services while receiving Shared Living, Assisted Living, or Nursing Facility services or receiving Adult Day Health Services while receiving Assisted Living or Nursing Facility services. Beneficiaries should also not receive Shared Living, Assisted Living, and Nursing Facility services simultaneously. As a result, the attribution hierarchy does not address those situations. In the event that a beneficiary is identified to have overlapping authorizations for these services, the MCO and/or EOHHS will validate the authorization information and ensure appropriate assignment. Where other discrepancies in the attribution are identified, the MCO and/or EOHHS may also validate and adjust the assignment as needed on a case-by-case basis.

Figure 1 summarizes the attribution rules when beneficiaries receive specialized LTSS AE attributable services from two or more providers in different AEs at the same time.

Figure 1: Attributing Beneficiaries Who Simultaneously Receive Attributable Services from Providers in Different AEs



NOTE: Figure 1 addresses only those scenarios in which beneficiaries receive attributable services from multiple providers simultaneously. As a result, it does not reference all types of attributable services.

Step 2: Validation of the attribution

No more than 5 calendar days after the first day of each month, each AE will receive a list of all Medicaid beneficiaries attributed to the AE from each MCO/payer. The AE will have 5 business days to identify and report any person actively receiving any of the attributable services in Table A who is not included in the attribution list. The MCO (for managed care enrolled members) and the State or its designee (for Medicaid fee-for-service beneficiaries) will validate the AE-reported information and update the attribution list as appropriate. Where other discrepancies in the attribution list are identified, the MCO/payer may also validate and adjust the assignment as needed on a case-by-case basis.

To be attributed to a specialized LTSS AE, an individual must be Medicaid eligible. He or she may be receiving services through either managed care or fee-for-service. The MCO/payer shall be required monthly to provide contracted AEs with electronic lists of attributed members, inclusive of identification of additions and deletions. These lists will be updated to reflect changes including new members, persons who have lost Medicaid eligibility, and persons whose attribution has changed pursuant to these guidelines.

2. Attachment A: Excerpts from EOHHS-MCO Contracts Regarding Assignment of Primary Care Providers

PCP assignment by the MCOs must comply with EOHHS contractual requirements. The following excerpts from Sections 2.05.07 and 2.05.08 of EOHHS' Medicaid Managed Care Services contracts with the MCOs describe the MCOs' contractual requirements related to PCP assignment:

2.05.07 **Assignment of Primary Care Providers (PCPs)**

Contractor shall have written policies and procedures for assigning each of its members who have not selected a primary care provider (PCP) at the time of enrollment to a PCP. The process must include at least the following features:

- The Contractor must allow each enrollee to choose his or her health professional to the extent possible and appropriate.
- If a Medicaid-only member does not select a PCP during enrollment, Contractor shall make an automatic assignment, taking into consideration such factors as current provider relationships, language needs (to the extent they are known), member's area of residence and the relative proximity of the PCP to the member's area of residence. Contractor then must notify the member in a timely manner by telephone or in writing of his/her PCP's name, location, and office telephone number, and how to change PCPs if desired. Contractor shall auto assign members to a NCQA recognized patient centered medical home, where possible.

Notwithstanding the above, the EOHHS recognizes the importance of members enrolling in a Patient Centered Medical Homes (PCMHs) and building a relationship with the Primary Care Provider (PCP). EOHHS expects that the Contractor to auto-assign to providers in a PCMH practice before auto assigning to non-PCMH providers. The Contractor will provide EOHHS with quarterly reports of the number and percent of total members assigned to PCMH sites either by auto-assignment or member choice. The Contractor is responsible for creating an auto- assignment algorithm and submitting this algorithm to EOHHS for review and approval within 90 days of the execution of this contract. Once this logic is approved by EOHHS, the health plan should operationalize this within 60 days. Contractor should consider the following when creating the algorithm: a) When auto assignment is being utilized, the Contractor must regularly monitor member panel size to ensure that providers have not exceeded their panel size; b) The provider's ability to comply with EOHHS's specified access standards, as well as the provider's ability to accommodate persons with disabilities or other special health needs must be considered during the auto-assignment process; c) In the event of a full panel or access issue, the algorithm for auto assignment must allow a provider to be skipped until the situation is resolved. Additionally, the Contractor will be required to provide registries of patients to each PCP facility where the patients are assigned, no less frequent than quarterly or at an interval defined by EOHHS.

- Contractor shall notify PCPs of newly assigned members in a timely manner.

- If a Medicaid-only member requests a change in his or her PCP, Contractor agrees to grant the request to the extent reasonable and practical and in accordance with its policies for other enrolled groups. It is EOHHS's preference that a member's reasonable request to change his or her PCP be effective the next business day.

Contractor shall make every effort to ensure a PCP is selected during the period between the notification to the Contractor by EOHHS and the effective date of the enrollee's enrollment in the Contractor's Health Plan. If a PCP has not been selected by the enrollee's effective date of enrollment, the Contractor will assign a PCP. In doing so, Contractor will review its records to determine whether the enrollee has a family member enrolled in the Contractor's Health Plan and, if so and appropriate, the family member's PCP will be assigned to the enrollee. If the enrollee does not have a family member enrolled in the Health Plan but the enrollee was previously a member of the Health Plan, the enrollee's previous PCP will be assigned by the Contractor to the enrollee, if appropriate.

2.05.08 Changing PCPs

Contractor shall have written policies and procedures for allowing members to select or be assigned to a new PCP including when a PCP is terminated from the Health Plan, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding. In cases where a PCP has been terminated, Contractor must allow members to select another PCP or make a re-assignment within ten (10) calendar days of the termination effective date.

Attachment B: Qualifying Primary Care Services as Identified by CPT Codes

Evaluation/Management CPT Codes: 99201-99205, 99211-99215

Consultation CPT Codes: 99241-99245

Preventive Medicine CPT Codes: 99381-99387, 99391-99397

Attachment N: Accountable Entity Road Map Document

Rhode Island Executive Office of Health and Human Services (EOHHS)
Medicaid Program Accountable Entity Roadmap Document



Date of Submission for Center for Medicare and Medicaid Services (CMS)
Review and Approval: Thursday, April 13, 2017

Table of Contents

| | | |
|-------|--|-----|
| I. | Roadmap Overview and Purpose | 192 |
| II. | Rhode Island's Vision, Goals and Objectives | 193 |
| III. | Our Approach | 194 |
| IV. | Progress to Date | 199 |
| V. | AE Program Structure | 204 |
| VI. | AE Certification Requirements | 206 |
| VII. | Alternative Payment Methodologies | 210 |
| VIII. | Medicaid Incentive Program (MIIP) | 212 |
| IX. | Program Monitoring, Reporting, & Evaluation Plan | 222 |
| | Appendix A: Stakeholder Meetings and Feedback | 226 |
| | Appendix B: Roadmap Required Components | 229 |

I. Roadmap Overview and Purpose

This Accountable Entity (AE) Roadmap is being submitted by the RI EOHHS, as the single state Medicaid agency in Rhode Island, to CMS for review and approval in accordance with Special Term and Condition (STC) 48 of Rhode Island's Health System Transformation Project (HSTP) Amendment to the state's 1115 Medicaid Demonstration Waiver.

The purpose of this document is to:

- Document the State's vision, goals and objectives under the Waiver Amendment.
- Detail the state's intended path toward achieving the transformation to an accountable, comprehensive, integrated cross-provider health care delivery system for Medicaid enrollees, and detail the intended outcomes of that transformed delivery system.
- Request review and approval by CMS, as is required before the state can begin payments of Medicaid Incentive Funds under the Waiver Amendment

The Accountable Entity "Roadmap" is a requirement of the Special Terms and Conditions (STCs) of RI's Health System Transformation Waiver (STC 48). The State must develop an Accountable Entity Roadmap for the Health System Transformation Project to be submitted to CMS for CMS's 60-day process of review and approval. The State may not claim FFP for Health System Transformation Projects until after CMS has approved the Roadmap. Once approved by CMS, this document will be incorporated as Attachment N of the STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved waivers, expenditure authorities and STCs. (Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols.)

The Accountable Entity Roadmap will be a conceptualized living document that will be updated annually to ensure that best practices and lessons that are learned throughout implementation can be leveraged and incorporated into the State's overall vision of delivery system reform. This Roadmap is not a blueprint; but rather an attempt to demonstrate the State's ambitions for delivery systems reform and to outline what the State and its stakeholders consider the payment reforms required for a high quality and a financially sustainable Medicaid delivery system.

This roadmap has been developed with input from participating MCOs, Accountable Entities and stakeholders. A draft roadmap was posted for public input in December 2016. Twenty-four (24) comments were received from a variety of stakeholders representing provider, insurers, and advocates. Thirteen (13) public input sessions were held between January and March 2017 to inform the final roadmap. A full list of public sessions can be found in **Appendix B**.

A detailed list of the required Roadmap elements, and the location of each element in this document, is provided in **Appendix C**.

II. Rhode Island's Vision, Goals and Objectives

Rhode Island's Medicaid program is an essential part of the fabric of Rhode Island's health care system serving one out of four Rhode Islanders in a given year and closer to thirty percent over a three- year period. The program has achieved national recognition for the quality of services provided, with Medicaid MCOs that are consistently ranked in the top ten in national NCQA rankings for Medicaid MCOs.

However, there are important limitations to our current system of care – recognized here in Rhode Island and nationally:

- It is generally fee based rather than value based,
- It does not generally focus on accountability for health outcomes,
- There is limited emphasis on a Population Health approach, and
- There is an opportunity to better meet the needs of those with complex health needs and exacerbating social determinants.

As such, the current system of care, both in Rhode Island and nationally, focuses predominantly on high quality medical care treatment of individual conditions – as is encouraged and reinforced by our fee for service (FFS) payment model. As a result of this model, there is often siloed and/or fragmented care, with high readmissions and missed opportunities for intervention. Specifically:

- *Within Medical Care:* There is limited focus on transitions, discharges, care coordination, and medication management across and between hospitals, specialists and primary care providers.
- *Between Medical Care and Behavioral Health care:* There is limited effective coordination between medical and behavioral providers, often acting as two distinct systems of care.
- *Complicated by growing needs of an aging population:* This will challenge medical models of care and require broader definitions of care (e.g., dementia, cognitive issues).
- *Between Medical Care and Social Determinants:* There is limited recognition and adaptation of a medical model that recognizes common factors impacting health of Medicaid populations – such as childhood trauma and its long-term impacts, mistrust of the health care system, etc. There is also limited capacity to address broader social needs, which often overshadow and exacerbate medical needs – e.g., housing/housing security, food security, domestic violence/sexual violence.

As a result, although individual providers are often high performing, **no single entity “owns” service integration, and no single entity is accountable for overall outcomes - only specific services.** Effective interventions must “break through” the financing and delivery system disconnects, to build partnerships across payment systems, delivery systems and medical/social support systems that effectively align financial incentives and more effectively meet the real life needs of individuals and their families.

These issues are particularly problematic when serving the most complex Medicaid populations -- the six percent of Medicaid users with the most complex needs and highest costs that account for almost two thirds (65%) of Medicaid claims expenditure. Specifically:

- **Populations receiving institutional and residential services**

Nearly half (45%) of claims expenditure on high cost users is on nursing facilities for the elderly and disabled, and on residential and rehabilitation services for persons with developmental disabilities.

- **Populations with integrated physical and behavioral health care needs**

Forty percent (40%) of claims expenditure on high cost users is for individuals living in the community, most (82%) of whom have multiple co-morbidities, with both physical and mental health or substance abuse needs that require an integrated approach.

The vision, as expressed in the Reinventing Medicaid report is for “...a reinvented Medicaid in which our Medicaid managed care organizations (MCOs) contract with Accountable Entities (AEs), integrated provider organizations that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population.”

The goals are consistent with initiatives taking hold across the country – a movement toward Accountable Care Organizations, including value based payment, new forms of organization, and increased care integration. **Specific goals of this initiative**, developed in alignment with SIM and other ongoing initiatives in our RI environment include:¹¹

- Transition from fee for service to value based purchasing
- Focus on Total Cost of Care (TCOC)
- Create population based accountability for an attributed population
- Build interdisciplinary care capacity that extends beyond traditional health care providers
- Deploy new forms of organization to create shared incentives across a common enterprise
- Apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs

As a result of this transformation of the Rhode Island Medicaid program (and in partnership with other efforts such as SIM), RI anticipates that **by 2022, Rhode Island will have achieved the following objectives:**

- Improvements in the balance of long term care utilization and expenditures, away from institutional and into community-based care;
- Decreases in readmission rates, preventable hospitalizations and preventable ED visits; and
- Increase in the provision of coordinated primary care and behavioral health services in the same setting.

This document establishes the Roadmap to achieve the vision, goals and objectives described here.

III. Our Approach

As stated above, the Rhode Island Accountable Entity Program is intended to “*break through the financing and delivery system disconnects, to build partnerships across payment systems, delivery*

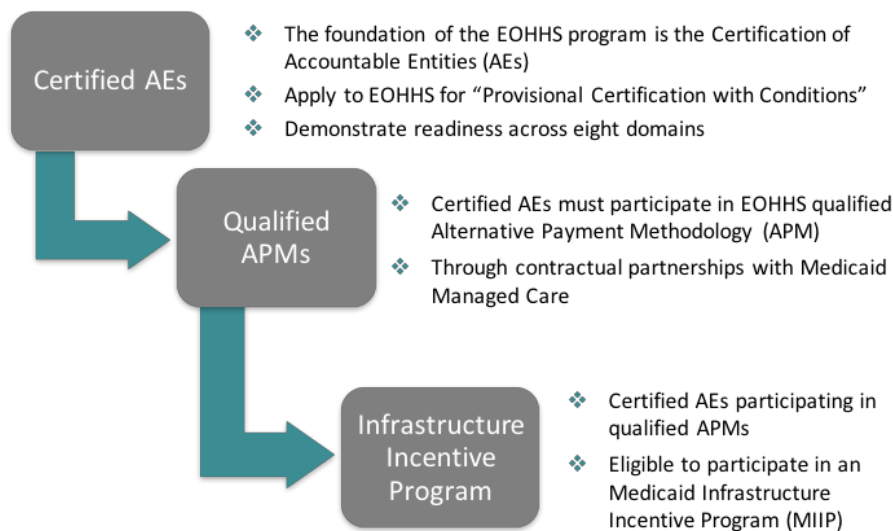
¹¹ RI’s Office of the Health Insurance Commissioner (OHIC) received a SIM (State Innovation Model) grant from CMS to test health care payment and service delivery reform models over the next four years, in a project called Healthy Rhode Island.

systems and medical/social support systems that effectively align financial incentives and more effectively meet the real life needs of individuals and their families.”

The Accountable Entity program shall be developed within, and in partnership with, Rhode Island’s existing managed care model, building on its existing strengths. The AE program will enhance the capacity of MCOs to serve high-risk populations by increasing delivery system integration and improving information exchange/clinical integration across the continuum.

Structurally, the Accountable Entity program includes three core “pillars”:

- (1) EOHHS **Certified Accountable Entities** and Population Health,
- (2) Progressive Movement toward EOHHS approved **Alternative Payment Methodologies**,
- (3) **Incentive Payments** for EOHHS Certified AEs, as depicted below:



Not all providers are at the same level of readiness for the interdisciplinary integration and transition to alternative payment methodologies envisioned by this program. As such, EOHHS is taking a **multi-pronged strategy**, in order to effectively “meet providers where they are” and enable the necessary system transformation. **EOHHS anticipates at least three specific programs:**

Phase 1: Comprehensive AE Program

EOHHS views the full development of high performing Comprehensive AEs as the core objective of its Health System Transformation Program. The Comprehensive AE Pilot already underway shall be expanded and enhanced for full implementation. The Comprehensive AE represents an interdisciplinary partnership of providers with a strong foundation in primary care and inclusive of other services, most notably behavioral health and social support services. The AE will be accountable for the coordination of care for attributed populations and will be required to adopt a defined population health approach.

Phase 2: Specialized LTSS AE Pilot Program

EOHHS is committed to improving the balance of long term care utilization and expenditures, away from institutional and into community-based care. Encouraging and enabling LTSS eligible and aging populations to live successfully in the community requires a focused approach. As such, we have defined two interim Specialized AE models: LTSS Pilot AEs and Medicaid Pre-Eligibles. Ultimately, EOHHS anticipates that specialized AEs will become integrated with Comprehensive AEs.

The long- term services and supports system in Rhode Island is fragmented and dominated by specialized providers who are geographically and/or service specific, and may have differing stages of readiness to engage in accountable systems of care. As such, the Specialized LTSS Pilot AE program is intended to encourage the development of critical partnerships across the LTSS spectrum of services to develop and enhance the necessary infrastructure to support a population management approach, as shown below. These specialized LTSS Pilot AEs will participate in alternative payment models that create appropriate financial incentives for participating providers to enable LTSS eligible populations to overcome barriers to live successfully in the community. The ability of an LTSS AE to address persons with behavioral health needs and dementia will be critical.

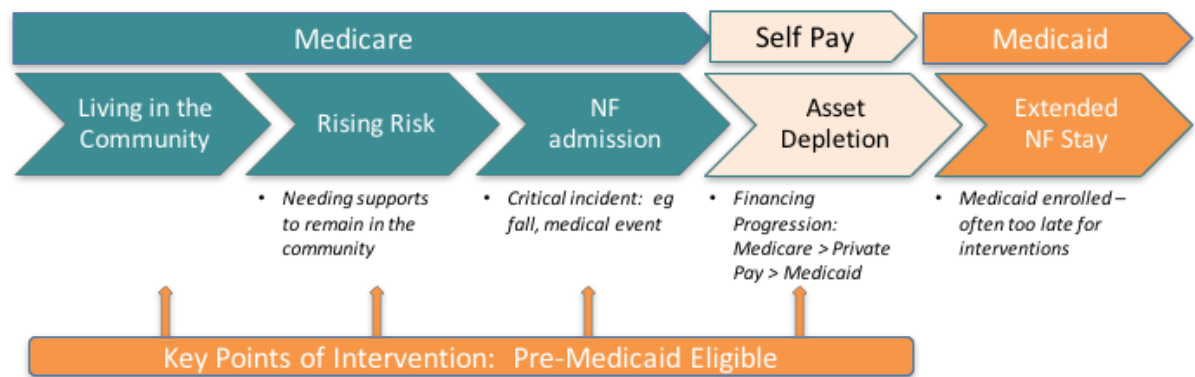


Multiple providers and groups of providers of LTSS services have expressed strong interest in this pilot. However, Rhode Island's LTSS system of care is fragmented and dominated by specialized providers who are geographically and/or service specific. Significant infrastructure development is required to build the necessary capacity and capabilities for these providers to effectively manage a population under a total cost of care model.

Phase 3: Medicaid Pre-Eligibles Pilot Program

Note that authority for this program shall be requested under the RI Medicaid Waiver renewal, to be submitted in December 2017 and effective January 1, 2019. EOHHS seeks to implement this program once it is approved under the waiver extension.

EOHHS is seeking Medicaid prevention/deferral strategies to enable and encourage aging populations to live successfully in the community. To be effective, EOHHS must work "upstream", and support people in the community who are not yet Medicaid eligible but are at high risk of becoming so when/if faced with a critical incident or depletion of resources. Effective programs in this arena must "break through" the financing system disconnects shown below to create financial incentives for participating providers.



As such, EOHHS will be in the process of developing a pilot program intended to engage high volume Medicare providers in the development and implementation of targeted interventions for Medicaid Pre-eligibles, especially at-risk populations residing in the community. This pilot is still in the design phase – to be implemented subject to approval by CMS under the 1115 Waiver Demonstration.

EOHHS anticipates that additional programs may be added over time, based on learnings from the current programs and pilots.

EOHHS is taking a phased approach to implementation, with a process and timeline that allows for the incorporation of ongoing learnings, as shown below:

| AE Type | Primary Target Population | Program Phase | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 |
|--|--|---|---------|---------|---------|---------|---------|---------|---------|---------|
| Comprehensive AE | Medicaid only | Program Design and Pilot Certification | | | | | | | | |
| | | Pilot Performance Period | | *** | | | | | | |
| | | Certification Renewal/ Full Certification | | | | | | | | |
| | | Full program performance period | | | | | | | | |
| Specialized LTSS | LTSS Eligibles* | Program Design and Pilot Certification | | | | | | | | |
| | | Pilot Performance Period | | | | *** | | | | |
| | | Certification Renewal/ Full Certification | | | | | | | | |
| | | Full program performance period | | | | | | | | |
| Medicaid Pre-Eligibles subject to CMS approval** | Medicaid LTSS Prevention: Medicare eligibles at risk of becoming duals | Program Design and Pilot Certification | | | | | | | | |
| | | Pilot Performance Period | | | | *** | | | | |
| | | Certification Renewal/ Full Certification | | | | | | | | |
| | | Full program performance period | | | | | | | | |
| *** Initial pilot performance period begins | | | | | | | | | | |
| * Includes duals and nonduals eligible for LTSS | | | | | | | | | | |
| ** Authority for this program shall be requested under the RI Medicaid Waiver renewal, to be submitted in Dec 2017 and effective 1/1/19. | | | | | | | | | | |

Note that the Comprehensive AE program is already underway, as Pilot AEs were certified in the fall of 2015 and APM contracts were in place between MCOs and Pilot AEs in 2016. EOHHS plans to move the Comprehensive AE program to full certification in CY 2017 with the first full

program performance period beginning in CY 2018. The two new pilot programs (Specialized LTSS AE and Medicaid Pre-Eligibles) will follow a similar trajectory, with staged implementation dates and targeted pilot performance periods in CY 2018 and CY2019 respectively.

EOHHS is committed to supporting this system transformation through our Medicaid Incentive Program (MIIP). An estimated \$76.8 Million in Health System Transformation Funds will be allocated to the MIIP, supporting MCOs and AEs in building the capacity and tools required for effective system transformation.¹² These funds must be used to support state defined priorities, in specified allowable expenditure areas, and will be tied to the achievement of AE and MCO specific projects, deliverables and milestones.

Effective implementation of this program will mean that **by 2022 at least one third (33%) of Medicaid eligibles will be attributed to an EOHHS Accountable Entity, participating in an EOHHS approved Alternative Payment Methodology (APM).** This goal will be accomplished in accordance with the following progression:

Percent of Medicaid covered lives attributed to an EOHHS approved APM

| Performance Year | Target |
|------------------|--------|
| DY 10 CY 2018 | 10% |
| CY 2019 | 15% |
| CY 2020 | 20% |
| CY 2021 | 25% |
| CY 2022 | 33% |

Beyond this Roadmap, **four core guidance documents will govern this program**, specifying requirements for EOHHS, MCOs and participating AEs:

| Core Documents | Targeted CMS Submission | Description |
|---|-------------------------|---|
| 1. AE Application and Certification Standards | Spring 2017 | <ul style="list-style-type: none"> • AE certification standards • Applicant evaluation and selection criteria • Submission guidelines |
| 2. APM Guidance | Fall 2017 | <ul style="list-style-type: none"> • Required components and specifications for each allowable APM structure • AE Scorecard • Areas of required consistency, flexibility |
| 3. Attribution Guidance | Fall 2017 | <ul style="list-style-type: none"> • Required processes for AE attribution, hierarchy |
| 4. Medicaid Incentive Program Guidance | Fall 2017 | <ul style="list-style-type: none"> • Additional details on funding allocation, required priorities, allowable areas of expenditure, milestones |

¹² Subject to available funds captured in accordance with CMS approved claiming protocols.

Note that EOHHS is continuously seeking input on these core programmatic guidance documents as follows:

- EOHHS shall hold public input sessions and participant working sessions with key stakeholders and interested public participants to refine each guidance document.
- Draft guidance shall be posted, comments received will be reviewed, and documents will be revised in consideration of public comments before final submission to CMS for approval.
For example, this Roadmap, including draft elements of each of these additional core documents, was posted in December 2016 and Stakeholders and participants provided many valuable comments which will be included in the final guidance
- The 1115 Waiver Taskforce provides an additional forum for public input. It is a statutorily defined (RIGL Chapter 42-12.4-9) committee, co-chaired by a senior state official of EOHHS/DHS and a member of the community and including representation from each population receiving Medicaid services. This group meets monthly. Medicaid AE's are a standing agenda item on the 1115 Waiver Task Force, thereby providing opportunity for a brief update on the status of the design and implementation.
- **On-going and ad-hoc Partner Meetings with MCOs and potential AE providers are held to cover emerging topics.**
- EOHHS holds AE Office Hours for stakeholders every other week. These meetings are scheduled through September, 2017; however, they will be continued past September, if needed.

IV. Progress to Date

EOHHS has made significant progress along several aspects of the Accountable Entity strategy. Key actions taken to date include:

1. Comprehensive AE Pilot Program Implementation
2. Specialized AE Pilot Program Development
3. Establishment of funding mechanism for Incentive payments

Key action steps to date in each of these areas are highlighted below.

1. Comprehensive AE Pilot Program Implementation

Rhode Island has already begun moving forward with the creation and support of Accountable Entities (AEs), while simultaneously testing critical program design elements. To approach the task of how to best advance such models in Rhode Island, EOHHS issued an RFI in August 2015 and received 14 responses with many thoughtful comments and recommendations. Based on feedback from the RFI and experience in other states, the state implemented an Accountable Entity Pilot Program as a **fast-track path and an opportunity for early learnings in late fall 2015**. EOHHS then provisionally certified Pilot AEs and issued companion documents specifying attribution rules and total cost of care guidance.

Pilots were certified with the understanding that:

- The state would be proceeding to move past the Pilot phase and, based on experiences and learnings from RI and across the country, would develop more extensive and refined certification standards. Applicants for pilot certification would be expected to comply with those new standards.
- The state would pursue opportunities with the federal government that, if successful, would enable state investments in the further development of AE capabilities.

To date, there have been three rounds of pilot AE applications. Applicants had to demonstrate readiness across three key design domains, including governance, organizational capability, and data/analytic capability. Qualified pilot applicants were “Provisionally Certified with Conditions”, which specified limitations to their contracting authority and confirmed required developmental steps and timelines.

The following six provider-based entities have been designated as Provisionally Certified Pilot AEs, eligible to enter into Total Cost of Care-based shared savings programs with Medicaid MCOs beginning in January 2016:

- Blackstone Valley Community Health Center’s HealthKey Accountable Entity
- Coastal Medical, Inc.
- Community Health Center Accountable Care Organization (CHC ACO)¹³
- Integra Community Care Network, LLC
- Providence Community Health Centers, Inc.’s Providence ChoiceCare AE
- Prospect Health Services Rhode Island, Inc. (PHSRI)

These six AEs were certified as “Type 1” AEs, meaning they are certified to contract for all services for a total attributed population. As of July 2016, **more than one third (1/3) of total Medicaid lives were attributed to participating pilot AEs under Total Cost of Care pilot terms, as shown below:**

AE Pilot: Attributed Lives

| Type 1 Attributed Lives | United | NHP | Total MCOs |
|--------------------------------|---------------|---------------|-------------------|
| Blackstone Valley (BVCHC) | | 8,933 | 8,933 |
| Integra (CNE, SCH & RIPCP) | 19,011 | 20,140 | 39,151 |
| PHSRI | 5,350 | 5,411 | 10,761 |
| PCHC Providence ChoiceCare AE | | 25,037 | 25,037 |
| CHC ACO+ | | 28,160 | 28,160 |
| Total Type 1 | 24,361 | 87,681 | 112,042 |

Sources and Notes: United and NHP attributed lives from Q4 2016 snapshot reports. Coastal was provisionally certified in July 2016 and has not yet contracted with the MCOs.

¹³ Community Health Center Accountable Care Organization (CHC ACO) currently includes East Bay Community Action Program (EBCAP), Comprehensive Community Action, Inc. (CCAP), Thundermist Health Center, Tri-Town Community Action Agency, WellOne Primary Medical & Dental Care, and Wood River Health Services.

1.

These AE pilot participants provide three different models of Comprehensive Accountable Care, which will allow significant opportunities for evaluation going forward. There are two hospital based entities, one multispecialty group practice, and three FQHC based models, all of which demonstrate a commitment to primary care infrastructure and an interdisciplinary approach.

2. Specialized AE Pilot Program Development

“Specialized” AEs are generally intended as an interim arrangement to enable providers to form networks that will build the capacity and infrastructure needed to manage specialized populations across providers. Over time, EOHHS intends that these Specialized AEs would partner with a Comprehensive AE.

In conjunction with the Comprehensive AE Pilot Program implemented in late fall, 2015, EOHHS included an opportunity for provisional certification of specialized “Type 2” Accountable Entities. Specifically, the Specialized Pilot Type 2 AEs was intended to encourage and enhance integrated care for persons with SPMI/SMI (Serious & Persistent Mental Illness/Serious Mental Illness), consistent with EOHHS’ goal of integrating physical and behavioral health services. As such, organizations with attributed SPMI/SMI populations were eligible to become “Type 2” AEs, eligible to participate in a total cost of care based shared savings arrangement with participating Medicaid MCOs.

In practice, the implementation of this type of Specialized AE resulted in the alignment of Specialized AEs with Comprehensive AEs. As such, EOHHS intends to sunset the Type 2 SPMI Specialized Accountable Entity, instead encouraging integration of SPMI populations with comprehensive AEs, as has already occurred in the market. EOHHS remains committed to continued improvements and enhancements in integrated care for persons with SPMI/SMI.

EOHHS is also working closely with stakeholders to develop a Specialized LTSS AE Pilot Program to focus on providers of long term services and supports (LTSS). Activities to support this initiative so far include:

- Establishment of key program goals
- Multiple discussions with key stakeholders and public meetings
- Research and evaluation of similar programs in other states
- Detailed discussions with key stakeholders regarding potential program structure, including attribution methods, APM models and performance metrics

Specialized LTSS-focused AEs are intended to achieve the rebalancing goals of Reinventing Medicaid by effectively enabling and encouraging aging populations to live successfully in the community. This requires creating sufficient financial incentives for current LTSS providers – nursing facilities, home and community based providers -- to work together to change the way care is delivered to our aging population. As such, the Specialized LTSS focused AE program shall:

- Support **focused investments** to build capacity and fill in gaps in infrastructure to more effectively address the needs of vulnerable seniors, supporting their ability to successfully remain in the community.
- Encourage and invest in the development of **integrated care delivery models**, such that providers build collaborative LTSS focused integrated care delivery systems that include a continuum of care. Ability to address persons with behavioral health needs and dementia will be critical.
- Encourage/require **alternative payment methodologies** that support this integrated system and that align financial incentives both across payors and between the state, MCOs and providers.
- Change financial incentives for Nursing Facilities – encourage them to reduce length of stay, increase quality, and send people home quicker.

EOHHS is also beginning to design a Medicaid Pre-Eligibles Pilot Program. The conceptual design as tested with stakeholders in the draft roadmap in January 2017 was met with strong interest and positive feedback, and initial design discussions have already begun with interested stakeholders. **Over the coming months, EOHHS intends to work** with CMS and local parties to design potential pathways for this innovative approach.

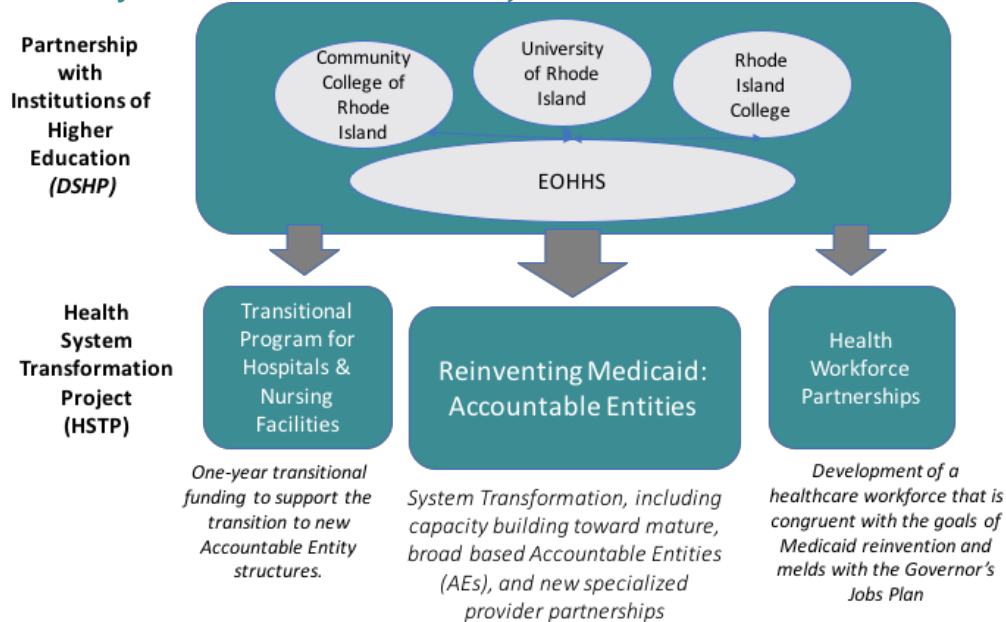
3. Establishment of funding mechanism for Incentive payments

Beginning in late 2015, EOHHS began pursuing Medicaid waiver financing to provide support for AEs by creating a pool of funds primarily focused on assisting in the design, development implementation, and administration of the infrastructure needed to support Accountable Entities. RI submitted an application for such funding in early 2016 as an amendment to RI's current Comprehensive Medicaid 1115 Waiver Demonstration. In October 2016 CMS approved this waiver amendment, for a federal share of \$129.8 million in federal financial participation (FFP) to RI from November 2016 through December 2020.¹⁴

This funding is based on the establishment of an innovative **Health Workforce Partnership** with RI's three public higher education institutions: University of Rhode Island (URI), Rhode Island College (RIC), and the Community College of Rhode Island (CCRI), as illustrated below.

¹⁴ The current Rhode Island 1115 Waiver is a 5-year demonstration, ending in 2018. The STCs include DSHP funding authority through 2018, with a commitment articulated in the cover letter to extend this authority thru 2020 upon waiver renewal for a total funding opportunity for a federal share of \$129 Million in federal financial participation (FFP).

Health System Transformation Project



The majority of the financing from this waiver amendment will be provided to AEs as incentive-based infrastructure funding via the state's managed care contracts. Other CMS-funded components include:

- Investments in partnerships with Institutions of Higher Education (IHEs) for statewide health workforce development and technical assistance to AEs
- One-time transitional funding to support hospitals and nursing facilities in the transition to new AE structures¹⁵
- Project management support to ensure effective and timely design, development, implementation, and administration of this program
- Project demonstration pilots and project evaluation funding to support continuous program learning, advancement and refinement
- Other supporting programs, including Consumer Assistance, Wavemaker Fellowship, TB Clinic, RI Child Audiology Center, and Center for Acute Infectious Disease Epidemiology

As mentioned above, the current RI 1115 Waiver expires December 31, 2018. The STCs of the waiver amendment include expenditure authority for this program up to \$79.9 million FFP through the end date of the current waiver.

¹⁵ The STCs limit this program to be one-time only and to not exceed \$20.5 million, paid on or before December 31, 2017.

V. AE Program Structure

EOHHS intends to expand and refine the current Pilot Accountable Entity Program to further support and encourage the development of Accountable Entities. As such, the Accountable Entity Program will include three core “pillars” as shown and described below. Each of these pillars will be articulated through specified arrangements with certified AEs. These three pillars are noted briefly here and described more fully later in this Roadmap.

The vehicle for implementing the AE initiative will be contractual relationships between the AE and Medicaid’s Managed Care partners. EOHHS, with stakeholder input, has established requirements for Accountable Entity certification as well as Managed Care performance requirements for AE contracts. Once an AE is certified by EOHHS, the AE is now eligible to enter a value based Alternate Payment contract (i.e. total cost of care/shared savings and/or risk model) with any of the State’s Medicaid MCOs based on the methodology established by EOHHS (total cost of care model, including quality measures, attribution, and incentive funding distribution) and in conformance with EOHHS contractual requirements as set forth in the contract between EOHHS and the MCO. The MCO and AE contract establishes the specific requirements and milestones associated with the administration of the AE program.

Medicaid MCOs are contractually required to increasingly enter into EOHHS approved value based APM contract arrangements. Certified AEs must enter into value based APM contracts in compliance with EOHHS guidelines in order to participate in member attribution, shared savings arrangements, and to be eligible to receive incentive-based infrastructure payments through the Health System Transformation Program.

Core Pillars of EOHHS Accountable Entity Program

1. EOHHS Certified Accountable Entities and Population Health

The foundation of the EOHHS program is the certification of Accountable Entities (AEs) responsible for the health of a population of members.

2. Progressive Movement toward EOHHS approved Alternative Payment Methodologies

Fundamental to EOHHS’ initiative is progressive movement from volume based to value based payment arrangements and movement from shared savings to increased risk and responsibility. Once an AE is certified, the AE must pursue value-based Alternative Payment Methodologies (APMs) with managed care partners in accordance with EOHHS defined guidance.

3. Incentive Payments for EOHHS Certified AEs

Incentive-based infrastructure funding will be available to state certified AEs who have entered into qualifying APM contractual agreements with managed care partners. As part of these agreements, AEs may earn incentive-based infrastructure funding under state-specified requirements. Note that Certified Specialized LTSS AE pilots may be eligible to participate in the Incentive Program for an initial six months prior to entering into qualifying APM contractual agreements with managed care partners, in order to support the immediate development of business critical partnerships and technical capacities needed to support an effective Alternative Payment Model.

Note that each of these pillars was developed with an effort to balance the following key principles:



- **Evidence Based**, leveraging learnings from our pilot, other Medicaid ACOs and national Medicare/Commercial experience
- **Flexible enough to encourage Innovation**, ACOs, and particularly Medicaid ACOs, are relatively new, and in many developmental areas clear evidence is not available
- **Robust enough to accomplish meaningful change**, and foster organizational commitments and true investments
- **Specific enough to ensure clarity and consistency**, recognizing that consistent guidelines provide clarity to participants

The following sections provide further detail on each of the three pillars.

VI. AE Certification Requirements

During the spring/summer of 2017, EOHHS will be formalizing the Certification Standards for Accountable Entities. Interested parties will then be invited to submit applications for certification and participation in the program. The issuance of AE Certification Standards, as well as the various stages of the application and approval process, will be managed directly by EOHHS. The final certification standards and application requirements will be based on a combination of the following:

- Learnings to date from the existing AE Pilot program
- National/emerging lessons from other states implementing Medicaid ACOs
- EOHHS multi-year participation in a Medicaid ACO Learning Collaborative facilitated by the Center for Health Care Strategies (CHCS) and sponsored by the Commonwealth Foundation
- Lessons learned from the existing Medicare ACO programs
- Alignment with SIM and the ACO standards as developed by the Rhode Island Office of the Health Insurance Commissioner (OHIC)
- Feedback and comments from stakeholders on the draft AE Roadmap, inclusive of Certification Standards, as posted in December 2016
- Discussion with stakeholders on features and details of AE Roadmap, inclusive of Certification Standards at specific meetings
- Feedback and comments from stakeholders gathered in public meetings/discussions during the beginning of 2017

EOHHS recognizes that potential applicants may have differing stages of readiness. The HSTP Program is intended as a catalyst for health system change, to induce these emerging organizations to develop new capacities and capabilities toward a new system of care that cares for the whole person and is accountable for both the outcome and cost of care.

As such, AEs will be annually certified, and EOHHS anticipates that most will be **“Provisionally Certified with Conditions” initially**. A provisionally certified entity means that the AE may not be fully compliant with all the organizational capabilities set forth in the certification requirements at the point of application but the AE has a strong application and a plan and commitment to further develop capabilities in key areas. **The outstanding need area or “conditions” shall highlight the gaps in AE capacities and capabilities that will be funded through the Medicaid Incentive Program.** These identified gaps will need to be addressed in accordance with an agreed upon project plan and timeline in order for the AE to continue to be eligible for Medicaid Incentive funds. Eventually, AEs who have demonstrated that all of the domain requirements were fully met will be designated as “Fully Certified”. “Full” certification is not required to be eligible for Medicaid Incentive funds.

EOHHS intends to certify three types of AEs:

1. **Comprehensive AEs**
2. **Specialized LTSS Pilot AEs**
3. **Specialized Medicaid Pre-Eligibles Pilot AEs**

Note that these AEs will serve distinct populations. As such, entities may apply to participate in

one or more programs, as long as readiness can be appropriately and specifically demonstrated.

1. Comprehensive AE Certification Standards

EOHHS has identified the critical domains considered instrumental to the success of Comprehensive AEs in meeting the needs of the Medicaid population through system transformation. Note that these requirements do not specify a particular organizational structure. EOHHS values multiple models of AE and encourages entities with different structures to apply (under the current pilot there are FQHC based, hospital based and primary care based Pilot AEs).

AE Applicants must meet minimum requirements in order to be considered for certification. Preliminary minimum requirements include:

- Minimum attributed lives
- Minimum Medicaid share of lives
- Demonstrated ability to collect, share, and report data
- Demonstrated level of behavioral health integration with primary care, with an established behavioral health provider organization
- Demonstrated affiliation or working arrangement with an SUD treatment provider
- Demonstrated affiliation or working arrangement with community based organizations to address broader social contexts impacting health, outcomes

Final requirements for qualified applicants shall be included in the AE application.

Qualified AE applicants will then be required to demonstrate their specific capacity to serve the requested populations by meeting requirements across the following domains. Preliminary detailed requirements for each of these domains are included in **Appendix A**.

- **Domain 1: Breadth and Characteristics of Participating Providers**
Interdisciplinary with demonstrated ability to serve a broad continuum of needs including social determinants for attributed populations. Must include a defined affiliation or working arrangement with community based organizations to address broader social contexts impacting health, outcomes.
- **Domain 2: Corporate Structure and Governance**
An adequate and appropriate governance structure to accomplish the program goals
- **Domain 3: Leadership and Management**
A leadership structure, with commitment of senior leaders, backed by the required resources to implement and support a single, unified vision
- **Domain 4: IT Infrastructure: Data Analytic Capacity & Deployment**
A core functional IT capacity to receive, collect, integrate, and utilize information
- **Domain 5: Commitment to Population Health and System Transformation**
A concerted program built on population health principles and systematically focused on the health of the entire attributed population. A systematic population health model that

works to improve the health status of the entire attributed population while systematically segmenting subpopulation risk groups with complex needs in order to implement focused strategies to improve their health status.

- **Domain 6: Integrated Care Management**

A comprehensive integrated care management program, including systematic processes and specialized expertise to identify and target populations. An organizational approach and strategy to integrate person-centered medical, behavioral, and social services for individuals at risk for poor outcomes and avoidable high costs.

- **Domain 7: Member Engagement & Access**

Capacity for effective member engagement, including strategies to maximize outreach, engagement, and communication with members in a culturally competent manner

- **Domain 8: Quality Management**

Ability to internally report on quality and cost metrics; to use those metrics to monitor performance, emerging trends, and quality of care issues; and to use results to improve care

It is EOHHS' expectation is that the AE shall be structured and organized to provide care for all populations, including adults and children. However, EOHHS recognizes that the necessary skills and capacities of an AE will vary considerably across populations. Specifically,

- **Children**, including children with special health care needs (CSHCN) and children with high, rising and low risk
- **Adults**, including adults with complex medical needs, co-occurring Behavioral Health/Medical, Homelessness, Substance Use Disorders, Other Disabilities, Intellectual and Developmental Disabilities.

As such, AE Certification may be specific to an approved population – Children, Adults – with attribution limited to the approved population. AE applicants will need to demonstrate the ability to meet the broad range of needs present in each identified population. Note that in some instances these capacities may be demonstrated by the AE itself, or through its relationship with participating MCOs.

To ensure that incentives are meaningfully and adequately sized, this will be a **competitive program**, with stricter requirements for certification beginning in year two.

Preliminary evaluation and selection criteria are as follows:

- **Demonstrated commitment to EOHHS priorities and Medicaid populations**
Demonstrated capabilities and capacities to serve the unique needs of the Medicaid population, and to address the goals and priorities described in Section 2.
- **Evidence of Readiness (*Domains 1-3*)**
Specific evidence of strong interdisciplinary network capacity, and an effective governance model and leadership team.
- **Data & Analytic Capacity (*Domain 4*)**
Demonstrated capacity to collect, integrate and utilize data to support decision-making.

- **System Transformation** (*Domains 5-8*)

Demonstrated commitment to, and capacity for, population health and system transformation, including a comprehensive, integrated and interdisciplinary care management program, effective member engagement strategies and a strong quality management program.

Final evaluation and selection criteria shall be included in the AE application.

2. Specialized AE Certification Standards: LTSS Pilot Certified AE

The objective of an LTSS Pilot AE will be to build integrated systems of care inclusive of a continuum of services for people, as appropriate, to be able to safely and successfully reside in a community setting. Eligible entities must demonstrate readiness across the same domains as listed above for Comprehensive AEs, with specific requirements within each domain that have been tailored to the specific needs of the LTSS eligible population and the current capacities of the LTSS provider community:

- Domain 1: Breadth and Characteristics of Participating Providers
- Domain 2: Organizational Structure and Governance
- Domain 3: Leadership and Management
- Domain 4: IT Infrastructure – Data Analytic Capacity and Deployment
- Domain 5: Commitment to Population Health and System Transformation
- Domain 6: Integrated Care Management
- Domain 7: Member Engagement and Access
- Domain 8: Quality Management

Note that the Pilot LTSS AE certification standards are intended as a starting point to engage individual providers in the challenging tasks of partnership development. EOHHS anticipates there may be multiple pilot LTSS AEs with different combinations of participating providers and different governance and care management models. Similar to the Comprehensive AE program, EOHHS intends to allow for multiple models under the pilot and will leverage learnings from the pilot to establish more rigorous standards for full implementation.

To ensure that incentives are meaningfully and adequately sized, this will be a **competitive pilot program**, with a limited number of selected participants, subject to available funding.

3. Specialized AE Certification Standards: Medicaid Pre-Eligibles Pilot Certified AEs

Certified Comprehensive AEs may also be eligible to participate in the Medicaid Pre-Eligibles Pilot program if they meet EOHHS specified criteria, to be developed in the coming months. Comprehensive AEs who are already working with Medicare populations (either through Medicare Advantage or Medicare ACO arrangements) are likely to provide the foundation for such a program.

VII. Alternative Payment Methodologies

Fundamental to EOHHS' initiative is progressive movement to EOHHS-approved Alternative Payment Methodologies (APMs), incorporating clear migration from volume based to value based payment arrangements and movement from shared savings to increased risk and responsibility.

The AE initiative will be implemented through Managed Care. AEs must enter into Managed Care contracts in order to participate in member attribution and shared savings within TCOC arrangements. These AEs will also be eligible to receive incentive payments from their Managed Care partner through the Health System Transformation Program. Correspondingly, MCOs must enter into qualified APM contracts (consistent with EOHHS defined APM guidance) with Certified AEs under the terms of their contracts with EOHHS.

As the primary contractor with EOHHS, the MCOs will retain accountability for ensuring compliance with all contractual requirements and related Federal managed care regulations. It is anticipated that successful development of an AE will include a defined yet dynamic distribution of responsibilities between the MCO and the AE, and that these will be identified in the written agreement between the parties. The distribution of roles and responsibilities may vary among AEs and MCOs to achieve the most effective combination. Performance of certain functions can be delegated to a subcontracting AE, but delegation will be with the expressed obligation to abide by managed care regulations and must be reviewed and approved by the State.

EOHHS is committed to maintaining member choice within the AE program structure. Members must have access to the right care, at the right time, and in the right setting. AE provider relationships may not impact member choice and/or the member's ability to access providers contracted or affiliated with the MCO. While AE based network limits, restrictions and fees are prohibited, MCOs and AEs may encourage utilization of preferred networks provided that rewards or positive financial incentives used are nominal and specifically linked with health-promoting plans of care. All incentives and methods of encouragement of preferred networks must be consistent with CMS requirements for Medicaid.¹⁶

EOHHS is also committed to ensuring that the proposed AE will not limit Medicaid beneficiary access to providers on the basis of AE attribution. It is not the intent of the accountable entity program to create new siloes of care within each system. In particular, AE affiliated hospitals and/or specialists may not in any way limit access to only AE participating providers.

Qualified APM contracts shall be in accordance with EOHHS defined APM guidance. This guidance shall be developed:

- leveraging learnings from the current pilot program guidance documents as

¹⁶ Next Generation ACO summary on CMS website: <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/index.html>. Next Generation ACO RFA, which includes section on beneficiary coordinated care rewards: <https://innovation.cms.gov/Files/x/nextgenacorfa.pdf>

- implemented in 2016,
- in alignment with Federal MACRA rules,
- in alignment with Rhode Island commercial requirements as established by the Office of the Health Insurance Commissioner, and,
- considering public and stakeholder input.

Note that the allowable APMs do NOT require a change to the underlying structure of payment between the MCOs and the AEs. Payment models that maintain the existing fee-for-service structure with a link to a set of quality indicators at risk, including a total cost of care overlay (thereby creating an opportunity for shared savings and risk between payors and providers) would qualify as an APM.

Each of the three AE Programs will specify qualifying APMs that will be based on a specified population of attributed lives, as defined in the table below. Within these respective populations, attribution to an AE shall be implemented in a consistent manner by all participating MCOs based upon EOHHS defined guidance, to be developed with input from stakeholders this spring and submitted for approval by CMS.

AE Attributable Populations

| Program | Attributable Populations |
|---|---|
| 1. Comprehensive AEs | Medicaid-only eligibles |
| 2. Specialized LTSS AEs | LTSS eligible, including duals and nonduals |
| 3. Specialized Medicaid Pre-Eligibles AEs | Medicare-only eligible |

The specific terms of the savings and risk transfer to the AE are at the discretion of the contracting parties. EOHHS does not intend to stipulate the terms of these arrangements but expects they will operate within the bounds of EOHHS defined APM Guidance. In addition, EOHHS does reserve the right to review and approve such arrangements.^{17, 18}

Additional program specific APM requirements are as follows:

Comprehensive AE Alternative Payment Methodology: Total Cost of Care

Managed Care Contracts with Comprehensive Accountable Entities must be based on total cost of care (TCOC) to be defined in forthcoming APM guidance from the EOHHS. These TCOC arrangements shall supersede and be exclusive of any other TCOC-related shared savings arrangements with an AE or any of its constituent providers. TCOC contracting between MCOs and AEs must meet guidelines set forth by EOHHS. MCOs are responsible to EOHHS for compliance in this matter. The MCOs will report to EOHHS outcomes on quality and financial performance by AEs on a schedule set forth in the Managed Care contract.

Qualified total cost of care (TCOC) contracts must incorporate the EOHHS Quality Scorecard.

A comprehensive quality score factor, based on the *Quality Scorecard*, must be applied to any shared savings and/or risk arrangements when calculating the total cost of care. A draft version of this *Quality Scorecard* has been posted

¹⁷ In addition to this EOHHS requirement, note that in certain circumstances transparency in such arrangements is specifically required in CFR42 §438.6.

¹⁸ CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. See <https://www.medicare.gov/federal-policy-guidance/federal-policy-guidance.html> and <https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/sharedsavingsprogram>

for public comment. The final *Quality Scorecard* will be modified, based on stakeholder input, and will align with the quality measures for Accountable Care Organizations (ACOs), which were endorsed by RI SIM. In addition to the required core measures, each MCO and AE may also include a limited number of additional measures from the SIM menu set, Medicaid Adult and/or Child Core Set. The quality calculation construct must be based upon a quality multiplier with a minimum threshold of allocated shared savings.

Qualified TCOC-based contractual arrangements must also demonstrate a progression of risk to include meaningful downside shared risk or full risk. By the end of the anticipated five-year waiver period in October 2021, infrastructure funding will be phased out. AEs will be sustained going forward based on their successful performance and associated financial rewards in accordance with their contract with MCOs.

2. Specialized LTSS Pilot AE: LTSS Bundle

Participating AEs will be responsible for the total cost of care. However, for dual eligible populations Medicare is primary for many services, with different arrangements depending on the program structure. As such, this interim APM arrangement will project the total cost of care for services included within the identified “bundle” of Long Term Services and Supports for the attributed population. This calculation will provide the basis for comparing actual financial experience with the projected financial experience.

The LTSS APM will also include a performance bonus for Pilot LTSS AE performance across a set of agreed upon dimensions. Given that EOHHS anticipates significant challenges in both capturing key data elements and measuring performance across populations, EOHHS would likely begin with a pay for reporting period for some components.

3. Specialized Medicaid Pre-Eligibles Pilot AEs

EOHHS sees an important opportunity in creating a targeted program to address Medicaid pre-eligibles. Previous studies of Medicaid migration patterns for long term care recipients here in Rhode Island have shown that much of the extended stay nursing home population is already in a nursing home when becoming eligible for Medicaid, likely having entered a nursing home and then spent down their assets until they became Medicaid eligible. This suggests that strategies to “rebalance,” away from expensive nursing home settings and toward more cost-effective community based care would benefit from a multi-payer approach, as these high risk individuals must be identified well before they spend down assets and become Medicaid eligible – before they enter a nursing home.

As this program is not slated to begin during this DY approval period, EOHHS intends to work with interested entities in the coming months to develop a reporting and data sharing arrangement that effectively enables combined Medicare and Medicaid population reporting and tracking for populations transitioning from Medicare to Medicaid.

VIII. Medicaid Incentive Program (MIIP)

Beginning in late 2015, EOHHS began pursuing Medicaid waiver financing to provide support for AEs by creating a pool of funds primarily focused on assisting in the design, development and implementation of the infrastructure needed to support Accountable Entities.

CMS has approved up to \$129.8 Million in HSTP program funds¹⁹. An estimated \$76.8 M shall be allocated to the AE Program, subject to available funds captured in accordance with CMS approved claiming protocols, as shown below. Under the terms of Rhode Island's agreement with the federal government, this is not a grant program. AEs must earn payments by meeting metrics defined by EOHHS and its managed care partners and approved by CMS to secure full funding.

| | SFY 17 | SFY 18 | SFY 19 | SFY 20 | SFY 21 | Total |
|----------------------------|--------|--------|--------|--------|--------|--------|
| Accountable Entity Program | \$0.0 | \$10.0 | \$29.4 | \$23.9 | \$13.5 | \$76.8 |

An AE Program Advisory Committee shall be established by EOHHS. This committee shall be chaired by EOHHS, with a community Co-Chair and shall include representation from participating MCOs, AEs, and community stakeholders and shall:

- Support the development of AE infrastructure priorities,
- Help target Medicaid Incentive Program funds to specific priorities that maximize impact
- Review specific uses of funds by each AE and MCO, such that individual AE Project plans are designed and implemented to maximum effect
- Monitor ongoing MCO/AE program performance
- Support effective program evaluation and integrated learnings

Detailed guidance for this program shall be set forth by EOHHS, with assistance from the AE Program Advisory Committee, in the final HSTP Guidelines for Health System Transformation Project Plans. Draft guidance shall be posted, comments received will be reviewed, and documents will be revised in consideration of public comments before final submission to CMS for approval.

A. Program Structure

The Medicaid Incentive Program (MIIP) shall consist of three core programs: (1) Comprehensive AE Program; (2) Specialized LTSS AE Pilot Program; and (3) Specialized Pre-eligibles AE Pilot Program. EOHHS shall allocate available HSTP funds to these three programs as follows, subject to available funds and EOHHS identification of priority areas of focus and assessment of readiness. This allocation shall be revisited annually.

| AE Programs | Share of Available AE Funds | |
|--|-----------------------------|--------------|
| | Program Year 1 | Full Program |
| Comprehensive AE Program | 60-70% | 60% - 70% |
| Specialized LTSS Pilot AE Program | 30-40% | 25% - 35% |
| Specialized Pre-eligibles Pilot AE Program | | 5%-15%* |

¹⁹ The current Rhode Island 1115 Waiver is a 5-year demonstration, ending in 2018. The STCs include DSHP funding authority through 2018, with a commitment articulated in the cover letter to extend this authority thru 2020 upon waiver renewal for a DSHP funding opportunity for a federal share of \$129 Million in federal financial participation (FFP).

*Authority for this program is dependent upon CMS approval under the RI Medicaid 1115 waiver extension, to be submitted to CMS in December 2017, effective January 1, 2019.

For each MCO the MIIP shall include three dimensions:



3. Maximum Total Incentive Pool (TIP) for MCOs

The maximum TIP for each MCO shall be determined by EOHHS with consideration to the MCO share of AE attributed lives in accordance with EOHHS defined attribution guidelines and associated reports.

4. MCO Incentive Program Management Pool (MCO-IMP)

Assuming satisfactory MCO performance, the MCO Incentive Program Management Pool shall minimally be eight percent (8%) of the Total Incentive Pool. To the degree that the MCO has more than the minimally required number of contracts with AEs, to be identified in a contract amendment, the MCO-IMP shall be increased by one percent for each AE contract to a maximum of ten percent. These funds are intended for use toward advancing program success, including program administration and oversight, assisting with the development of the necessary infrastructure to support a new business model, and establishing shared responsibilities, information requirements and reporting between EOHHS, the MCO and the Accountable Entities.

5. Accountable Entity Incentive Pool (AEIP)

The Accountable Entity Incentive Pool shall equal the Total Incentive Pool minus the MCO Incentive Program Management Pool ($AEIP = TIP - MCO-IMP$). This pool shall be divided into the three distinct programs as specified above. In developing contracts with AEs, MCOs shall propose AE Infrastructure Payment Criteria and Methodology for EOHHS review and approval that are consistent with EOHHS defined guidance. This shall determine the total annual amount and schedule of incentive payments each participating AE may be eligible to receive from the Accountable Entity Incentive Pool.

3a. Accountable Entity Specific Incentive Pools

Certified AEs in qualified Alternative Payment Methodology (APM) contracts consistent with EOHHS guidance must be eligible for the Medicaid Incentive Program. Each MCO must create an AE Incentive Pool for each Certified AE to establish the total incentive dollars that may be earned by each AE during the period. The Pool calculation shall include a base amount plus a ppm component based on attributed lives at the start of each contract year in accordance with EOHHS defined guidance. An example of an AE Incentive Pool calculation for a sample AE is shown below – please note the numbers shown here are

illustrative only.

AE #1 Incentive pool Year 1: Illustrative Example Calculation

AE 1 has 15,000 attributed lives, 10,000 are with MCO 1, and 5,000 with MCO 2

Payments from each MCO are for distinct attributed populations and therefore not duplicative.

| | MCO 1 | MCO 2 | Total | | | |
|----------------------------|------------------|------------------|------------------|---|--------------|--|
| Attributed lives | 10,000 | 5,000 | 15,000 | Illustrative Example Assumptions | | |
| Base Amount | \$200,000 | \$200,000 | \$400,000 | \$200,000 | base per MCO | |
| pmpm | \$ 180,000 | \$ 90,000 | \$270,000 | \$ 1.50 | pmpm | |
| AE 1 Incentive Pool | \$380,000 | \$290,000 | \$670,000 | | | |

3b. Performance Based Incentive Payments

AEs must develop individual Health System Transformation project plans that identify clear project objectives and specify the activities and timelines for achieving the proposed objectives. Actual AEIP incentive payment amounts to AEs will be based on demonstrated AE performance. Incentive payments actually earned by the AE may be less than the amount they are potentially eligible to earn. MCOs shall not be entitled to any portion of funds from the Accountable Entity Incentive Pool that are not earned by the AE.

Reconciliation

In advance of the MCOs payments to AEs, the MCO shall receive payment from EOHHS in the amount and schedule agreed upon with EOHHS. Any Incentive Program funds that are not earned by EOHHS Certified AEs as planned during a given contract year shall be tracked and retained by the MCO exclusively for future Accountable Entity Incentive Pool uses during the following contract year. Any funds not earned during the following contract year shall be returned to EOHHS within thirty days of such request by EOHHS. An AE's failure to fully meet a performance metric within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment). An AE that fails to meet a performance metric in a timely fashion can earn the incentive payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with on-time performance on the next metric in the performance sequence, in accordance with the requirements for Material Modifications described in Section VIII.C.3 of this document.

B. Program Spending Guidance

Incentive Program funds are designed to be used by AEs to prepare project plans and to build the capacity and tools required for effective system transformation. Allowable expenditures must align with EOHHS program priority areas and shall be distributed by the MCOs to the AEs in designated performance areas.



Allowable Areas of Expenditure

Allowable uses of funds include the following three core areas and eight domains. Costs must be reasonable for services rendered.

| Domains | Allowable Uses of Funds | Allowable Expenditure Mix | | |
|---|---|---------------------------|--------|------|
| | | Yr 1 | Yr 2-3 | Yr 4 |
| A. Readiness | | <50% | <25% | <10% |
| 6. Breadth and Characteristics of Participating Providers | <ul style="list-style-type: none">Building provider base, population specific provider capacity, interdisciplinary partnerships, developing a defined affiliation with community based organizations (CBOs)Developing full continuum of services, Integrated PH/BH, Social determinants | | | |
| 7. Corporate Structure and Governance | <ul style="list-style-type: none">Establishing a distinct corporation, with interdisciplinary partners Joined in a common enterprise | | | |
| 8. Leadership and Management | <ul style="list-style-type: none">Establishing an initial management structure/staffing profileDeveloping ability to manage care under Total Cost of Care (TCOC) arrangement, with increased risk and responsibility | | | |
| B. IT Infrastructure | | 30% | 30% | 30% |
| 9. Data Analytic Capacity and Deployment | <ul style="list-style-type: none">Building core infrastructure: EHR capacity, patient registries, Current CareProvider/care managers’ access to information: Lookup capability, medication lists, shared messaging, referral management, alertsPatient portalAnalytics for population segmentation, risk stratification, predictive modelingIntegrating analytic work with clinical care: Clinical decision support tools, early warning systems, dashboard, alertsStaff development and training – individual/team drill downs re: conformance with accepted standards of care, deviations from best practice | | | |
| C. System Transformation | | 20% | 45% | 70% |
| 10. Commitment to Population Health and System Transformation | <ul style="list-style-type: none">Developing an integrated strategic plan for population health that is population based, data driven, evidence based, client centered, recognizes Social Determinants of Health, team based, integrates BH, IDs risk factorsHealthcare workforce planning and programming | | | |
| 9. Integrated Care Management | <ul style="list-style-type: none">Systematic process to ID patients for care management | | | |

| | |
|----------------------------------|--|
| | <ul style="list-style-type: none"> • Defined Coordinated Care Team, with specialized expertise and staff for distinct subpopulations • Individualized person centered care plan for high risk members |
| 10. Member Engagement and Access | <ul style="list-style-type: none"> • Defined strategies to maximize effective member contact and engagement • Use of new technologies for member engagement, health status monitoring and health promotion |
| 11. Quality Management | <ul style="list-style-type: none"> • Defined quality assessment & improvement plan, overseen by quality committee |

EOHHS anticipates that spending may be heavily weighted toward the Readiness Core Area (domains 1-3) in year one, as AEs build the capacity and tools required for effective system transformation. However, over time the allowable areas of expenditure will be required to shift toward system transformation (domains 5-8). A preliminary allowable mix of expenditures is shown above.

Program Priorities

Each MCO's AE Incentive Pool budget and actual spending must align with the priorities of EOHHS as developed with the support of the Advisory Committee and shown below. Note: This is a draft set of priorities – a final set of priorities shall be reviewed and confirmed by the Advisory Committee, and specified in the final APM guidance document.

| Program | Priorities |
|-----------------------------------|--|
| Comprehensive AEs | <ul style="list-style-type: none"> • Planning and core infrastructure development • Medical enhancements: enhanced systems of care, workforce development <ul style="list-style-type: none"> ○ For children ○ For Adults • Integration and innovation in behavioral health care <ul style="list-style-type: none"> ○ For children ○ For Adults • Integration and innovation in SUD treatment • Integration and intervention in social determinants, including cross system impacts |
| Specialized Pilot LTSS AEs | <ul style="list-style-type: none"> • Building partnerships, including governance, leadership and financial arrangements, between LTSS providers. • Developing programs and care coordination processes towards effective and timely care transitions and reduced institutional/ED utilization • Repurposing skilled nursing capacity for acute psychiatric transitions and/or adult day capacity • Home and Community based Behavioral Health capacity development for behavioral health specialized adult day care, home care, and alternative living arrangements. |

| | |
|---|---|
| Specialized Medicaid Pre-Eligibles AEs | <ul style="list-style-type: none"> Developing processes, tools and protocols for identification of at risk Medicaid pre-eligible populations Developing effective and evidence based interventions to support community based care for these populations. EOHHS is committed to working with these entities to define and develop opportunities (mechanisms to pay for) for the specific services needed for identified Medicaid pre-eligible populations that may not currently be Medicare covered services – e.g., home based primary care, palliative care, community health workers, etc. <i>Note that authority for this program shall be requested under the RI Medicaid Waiver renewal, to be submitted in March of 2018 and effective January 1, 2019. EOHHS seeks to implement this program once it is approved under the waiver extension.</i> |
|---|---|

Performance Areas

AEs must develop AE Specific Health System Transformation Project Plans. These plans shall specify the performance that would qualify an AE to earn incentive payments. Earned funds shall be distributed by the MCO to the AE in accordance with the distribution by performance area defined in the AE specific Health System Transformation Plan, consistent with the requirements defined below:

| Performance Area | Minimum Milestones | Year 1 | Year 2 | Year 3 | Year 4 |
|---------------------------------------|--|------------|------------|------------|------------|
| Planning and Design | <ul style="list-style-type: none"> Execution of Contract, Initial Workplan & budget for developing an AE Project Plan, including completed EOHHS Budget Template Detailed AE Gap Analysis, with specified impacts by domain and population | 70% | 15% | 0% | 0% |
| Developmental Milestones | <ul style="list-style-type: none"> Detailed Health System Transformation Project Plan, including proposed Infrastructure Development Budget by Project, Domain and population, in accordance with state specified template Quarterly Progress Report in accordance with state defined template Quarterly financial report, in accordance with state defined template, including documented evidence of expenditures Developmental milestones MCO/AE Defined (at least 3 unique developmental milestones per year) | 30% | 85% | 75% | 50% |
| Value based purchasing metrics | <ul style="list-style-type: none"> Demonstrated APM Progression Marginal Risk Requirements Minimum required share of marginal risk for which the AE is liable, in accordance with EOHHS define APM guidelines | 0% | 0% | 20% | 30% |
| System Performance Metrics | <ul style="list-style-type: none"> Preventable Admissions Readmissions Avoidable ED Use MCO/AE Specific Performance Targets (up to 3) | 0% | 0% | 5% | 10% |

| | | | | | |
|--------------------------|--|-----------|-----------|-----------|------------|
| Final Deliverable | | 0% | 0% | 0% | 10% |
|--------------------------|--|-----------|-----------|-----------|------------|

The early milestones are intended to allow AEs to develop the foundational tools and human resources that will enable AEs to build core competencies and capacity. In accordance with EOHHS' agreement with CMS, participating AEs must fully meet milestones established in the AE specific health system transformation plan prior to payment. EOHHS recognizes the financial constraints of many participating AEs, and that timely payment for the achievement of early milestones will be critical to program success.

These AE-specific HSTP project plans may only be modified with state approval, in accordance with the Material Modification requirements outlined in section C.3 below, and further specified in the EOHHS Guidelines. EOHHS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.

C. Implementation and Oversight

As described above, the Medicaid Incentive Program (MIIP) includes EOHHS **program priority areas, allowable areas of expenditure, and AE specific performance areas** that qualify an AE to earn incentive payments. With the assistance of the Advisory Committee EOHHS will develop "EOHHS Guidelines for Health System Transformation Project Plans" that will further specify each of these program elements. This guidance will define specific implementation requirements that must be adhered to by AEs and MCOs to ensure that incentive programs are designed and implemented to maximum effect.

Four key elements of these implementation requirements to be further stipulated in the guidelines are as follows:

1. Specifications Regarding Allowable HSTP Project Plans

Specifications shall delineate additional details regarding:

- Core Goals
- Allowable Priority areas
- Allowable Areas of Expenditure
- Required Performance Areas
- Characteristics of approvable project plans:
 - Approvable project plans must demonstrate how the project will advance the core goals and identify clear objectives and steps for achieving the goals.
 - Approvable project plans must set timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance.

2. MCO Review Committee Guidelines for Evaluation

The MCO shall convene a review committee to evaluate each proposal. EOHHS shall have a designee that participates on the MCO submission evaluation committee to ensure the state's engagement in the process to evaluate the project plan and associated

recommendations for approval or disapproval. The MCO Review Committee, in accordance with EOHHS guidelines, shall determine whether:

- **Project as submitted is eligible for award**

Eligible projects will include a project plan that clearly address EOHHS priority areas and clearly includes the types of activities targeted for funds.

- **Project merits Incentive Funding**

Projects must show appropriateness for submission for this program by including the following:

- Clear statement of understanding regarding the intent of incentive dollars
- Rationale for this incentive opportunity, including a clear description of objective for the project and how achieving that objective will promote health system transformation for that AE
- Confirmation that project does not supplant funding from any other source and is non-duplicative of submission that may be made to another MCO
- High quality proposal that includes a gap analysis, explains how the workplan and budget addresses these gaps, and describes the AE's current strengths and weaknesses in this area
- Clear interim and final project milestones and projected impacts, as well as criteria for recognizing achievement of these milestones and quantifying these impacts

- **Incentive Funding request is reasonable and appropriate**

The funding request must be reasonable for the project identified, with funds clearly dedicated to this project. The level and apportionment of the incentive funding request must be commensurate with value and level of effort required.

3. **Material Modification of HSTP Project Plans**

EOHHS guidelines shall delineate additional details regarding material modification requests, to include:

- **Definition**

A Material Modification includes any change to the metrics, deadlines or funds associated with an HSTP Project Plan. Failure to meet performance metrics shall be considered a material modification.

- **Material Modification Request Submission**

An official request must be submitted in writing by the AE to the MCO, including the following:

- A brief description of the requested change
- A clear statement of purpose, or justification for the modification
- A brief statement of the anticipated impact the change will have on the project plan, timeline and goals
- A listing of any proposed changes in specific metrics or deadlines

- **Review Process and Criteria**

Any material modification to the HSTP Project Plans must be reviewed and approved by the MCO Review Committee. Material modifications that either delay the project by more than 3 months or impact more than 15% of HSTP funding must also be approved by the AE Advisory Committee. Material modification requests must be reasonable for the project identified, with clear revisions to the project milestones, metrics and

timelines commensurate with the scope of the modification. In instances where an AE fails to meet (or anticipates that it will not meet) a performance metric, fully achieving the original metric (within one year of the original performance deadline) in combination with on-time performance on the next metric in the performance sequence shall qualify as an acceptable modification.

4. Required Structure for Implementation

The Incentive Funding Request must be awarded to the AE via a Contract Amendment between the MCO and the AE. The Contract Amendment shall:

- Be subject to EOHHS review and approval
- Incorporate the central elements of the approved AE submission, including:
 - Stipulation of program objective
 - Scope of activity to achieve
 - Performance schedule
 - Payment terms – basis for earning incentive payment(s) commensurate with the value and level of effort required.
- Define a review process and timeline to evaluate progress and determine whether AE performance warrants incentive payments. The MCO must certify that an AE has met its approved metrics as a condition for the release of associated Health System Transformation Project funds to the AE.
- Minimally require that AEs must submit semi-annual reports to the MCO using a standard reporting form to document progress in meeting quality and cost objectives that would entitle the AE to qualify to receive Health System Transformation Project payments, and that such reports will be shared directly by the MCO with EOHHS.
- Stipulate that the AE must earn payments through demonstrated performance. The AE's failure to fully meet a performance metric under its AE Health System Transformation Project Plan within the timeframe specified will result in forfeiture of the associated incentive payment (i.e. no payment for partial fulfillment).

Provide a process by which an AE that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated Health System Transformation Project Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with on-time timely performance on the next metric in the performance sequence.

IX. Program Monitoring, Reporting, & Evaluation Plan

Rhode Island has an established track record of expansions and improvements to its managed care programs as well as a systematic and active program of oversight of our contracted MCOs. The development of the Accountable Entities program provides a new and significant opportunity to further transform the performance of our delivery systems and improve health outcomes for Rhode Island's Medicaid population.

Rhode Island initiated its first managed care program in 1994 with the enrollment of children and families into its RItE Care program. In the years following there have been many changes in the structure of the program so that it now includes the large majority of Medicaid covered beneficiaries, a broad range of Medicaid covered services with very few service "carve outs", and an array of program initiatives intended to advance program effectiveness and cost efficiencies. At each step along the way we have adapted and expanded our program oversight activities to promote high quality performance and ensure program compliance.

Rhode Island's Accountable Entity program is designed to work within and in partnership with our managed care program. Certification of AEs is performed directly by EOHHS, establishing their eligibility to participate in the program. Annual certification ensures continued compliance with requirements to retain eligibility. Eligible AEs will then contract with managed care organizations within the requirements set forth by EOHHS. As the primary contractors with EOHHS, the MCOs will be directly accountable for the performance of their subcontractors. EOHHS is responsible for overseeing compliance and performance of the MCOs in accordance with EOHHS contractual requirements and federal regulation, including performance of subcontractors.

The AE program, AE performance, and MCO-AE relations will be integrated into existing EOHHS managed care oversight activities. For this initiative EOHHS will build upon and enhance its program monitoring and oversight activities in the following four key areas, each of which is described below:

1. MCO Compliance and Performance Reporting Requirements
2. In-Person Meetings with MCOs
3. State Reporting Requirements
4. Evaluation Plan

1. MCO Compliance and Performance Reporting Requirements

Under current contract arrangements, MCOs submit regular reports to EOHHS across a range of operational and performance areas such as access to care, appeals and grievances, quality of care metrics, consumer experience, program operations and others. EOHHS reserves the right to review performance in any area of contractual performance, including flow down requirements to Accountable Entity subcontractors.

For this initiative, MCO reporting requirements that have more typically been provided by the MCOs and reviewed by EOHHS at the plan-level will be extended to also require reporting at the

AE level. A menu of metrics and measures that will be used by the MCOs to assess the performance of the AEs and that will be reported to EOHHS will be further specified in the final APM guidance document. Areas of current reporting that are under review as requirements for MCOs to report on data aggregated at the Accountable Entity level include:

| MCO Required Reports | Description |
|---|---|
| 1. Provider Access Survey Report | Report completed by each Health Plan by the following provider types: primary care, specialty care, and behavioral health for routine and urgent care. This report measures whether appointments made are meeting Medicaid accessibility standards. |
| 2. Provider Panel Report | A report of which provider panels by each Health Plan are at capacity and/or closed to enrollees. |
| 3. Appeal and Grievance Report | An aggregate report of clinical and administrative denials and appeals by each Health Plan, including External Review. |
| 4. Informal Complaint Report | An aggregate report of the clinical and administrative complaints specified by category and major provider sub-groups for each Health Plan |
| 5. Accountable Entity Shared Savings Report | This financial report is included as part of each Health Plan's risk share report and provides financial data and information as to how each Accountable Entity is performing relative to their total cost of care benchmark. |
| 6. Quality Scorecard | This report consists of the set of NCQA HEDIS and other clinical and quality measures that are used to determine the quality multiplier for total cost of care. |
| 7. MCO Performance Incentive Pool Report | Detailed budgeted and actual MCO expenditures in accordance with EOHHS defined templates |

In addition to enhancement of current reports, the Medicaid MCOs will be required to submit reports on a quarterly basis that demonstrate their performance in moving towards value based payment models, including:

- Alternate Payment Methodology (APM) Data Report
- Value Based Payment Report

Pertaining more directly to AE program operations, the Medicaid MCOs will be required to submit Accountable Entity specific reports, including the following.

- AE Attributed Lives
This quarterly report will provide EOHHS with the number of Medicaid MCO lives attributed to each specific Accountable Entity as well as in total.
- AE Population Extract File
This monthly report will provide EOHHS with a member level detailed report of all Medicaid MCO members attributed to each AE. This data will be used by EOHHS for data validation purposes as well as for the purposes of ad-hoc analysis.
- AE Participating Provider Roster
This monthly provider report will provide EOHHS with an ongoing roster of the AE provider network, inclusive of provider type/specialty and affiliation (participating, affiliated,

referral etc.) to the Accountable Entity.

2. In-Person Meetings with MCOs

As part of its ongoing monitoring and oversight of its MCOs, EOHHS conducts an in-person meeting on a monthly basis with each contracted MCO. These meetings provide an opportunity for a more focused review of specific topics and areas of concerns. Additionally, they provide a venue for a review of more defined areas of program performance such as quality, finance, and operations. During the initial pilot phase with comprehensive AEs and as the program moves forward, these meetings provide an important forum to identify and address statewide AE performance, emerging issues, and trends that may be impacting the AE program. In addition to the reporting noted above, these meetings support EOHHS' ability to report to CMS (in quarterly waiver reports) issues that may impact AE's abilities to meet metrics or identify factors that may be negatively impacting the program.

In support of discussion on AEs at these meetings, MCOs will be required to submit reports on such areas as:

- A description of actions taken by the MCO to monitor the performance of contracted AEs
- The status of each AE under contract with the MCO, including AE performance, trends, and emerging issues
- A description of any negative impacts of AE performance on enrollee access, quality of care or beneficiary rights
- A mitigation/corrective action plan if any such negative impacts are found/reported

Monthly meetings with MCOs provide a structured venue for oversight. At the same time, EOHHS communications with MCOs take place daily on a variety of topics. Additional meetings to address particular areas of concern that may arise are a routine part of EOHHS' oversight activities. Rhode Island's small size greatly facilitates these in person interactions with both MCOs and AEs.

3. State Reporting Requirements

The state will incorporate information about the Health System Transformation waiver amendment into its existing requirements for waiver reports, including quarterly, annual, and final waiver program reports, and financial/expenditure reports. In addition, the state shall supply separate sections of such reports to meet the reporting requirements in the STCs that are specific to the Health Systems Transformation waiver amendment.

The state will provide quarterly expenditure reports to CMS using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority subject to budget neutrality. This project is approved for expenditures applicable to allowable costs incurred during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the expenditures as specified in Section XVI of the STCs.

The state will also separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for all expenditures under the demonstration, including HSTP Project Payments, administrative costs associated with the demonstration, and any other expenditures specifically authorized under this demonstration. The report will include:

- A description of any issues within any of the Medicaid AEs that are impacting the AE's ability to meet the measures/metrics.
- A description of any negative impacts to enrollee access, quality of care or beneficiary rights within any of the Medicaid AEs.

4. Evaluation Plan

EOHHS will draft an Evaluation Plan, which will include a discussion of the goals, objectives, and evaluation questions specific to the entire delivery system reform demonstration.

Key areas of attention in the evaluation will tie to the goals and objectives set forth in this Roadmap, as specified in Section II. The draft Evaluation Plan shall list 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 Plan will include a detailed description of how the effects of the demonstration will be isolated from other initiatives occurring within the state (i.e., SIM grant activities). The draft Evaluation Plan will include documentation of a data strategy, data sources, and sampling methodology.

The state will issue an RFP, based on the CMS-approved evaluation plan, for a qualified independent entity to conduct the evaluation. The Evaluation Plan will describe the minimum qualifications of the evaluation contractor, a budget, and a plan to assure no conflict of interest.

- XVI.** The state plans to submit an Interim Evaluation Report of the Accountable Entities program to CMS by 90 calendar days following the completion of DY 4. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings and describe plans for completing the evaluation plan. The state also plans to submit a Final Evaluation Report after the completion of the demonstration.

Appendix A: Stakeholder Meetings and Feedback

EOHHS has presented to thirteen (13) stakeholder meetings regarding the HSTP/AE Program.

- HSTP/AE Presentation to ICI Provider Council
- HSTP/AE presentation to 1115 Task Force
- AE/MCO meetings on AE initiative (2 sessions)
- Broad Stakeholder meeting/presentation on Comprehensive AEs (2 sessions)
- Stakeholder meeting on Specialized AEs
- HSTP/AE meeting to home care/child service providers
- NASW Aging Committee meeting
- Coalition for Children presentation
- Governor BH council (scheduled)
- BHDDH Health Transition team (scheduled)
- DEA Home and Community Care Advisory Committee (scheduled)

Additionally, twenty-four (24) comments were received by EOHHS from the following interested parties:

1. Blackstone Valley Community Health Center
2. Carelink
3. Center for Treatment and Recovery
4. CHC ACO
5. Coalition for Children and Families
6. Coastal Medical
7. Disability Law Center
8. Economic Policy Institute
9. Integra
10. Kids Count
11. LeadingAge
12. Lifespan
13. Neighborhood Health Plan of Rhode Island
14. Partnership for Home Care
15. Prospect Health Services of RI
16. Providence Community Health Center
17. RI Coalition for Children
18. RI Community Action Agencies
19. RI Health Care Association
20. RI Health Center Association
21. State of Rhode Island SIM Team
22. Substance Use and Mental Health Leadership Council
23. Tufts Health Public Plans
24. UnitedHealthcare

Many of these comments provided valuable input to the final roadmap as documented here. Some required additional discussion, and were further refined through public input sessions in March 2017, prior to finalizing the roadmap.

Note that the draft roadmap that was posted in January 2017 for comments included both an in-depth discussion of Rhode Island's vision, goals and objectives of Rhode Island's AE program, as well as appendices that outlined initial details of programmatic guidance for AEs. As such, many of the comments received were more directly related to future anticipated guidance – either APM guidance, Incentive Program Guidance or Attribution guidance, and shall be addressed as part of that public input process.

The following is a summary of the comments received by thematic areas.

State Policy Alignment

A number of comments spoke to the need to ensure that state policy outside of the Accountable Entity program was aligned to ensure success. Detailed points of alignment included:

- Statutory authority for data sharing
- Budgetary support for the Integrated Care Initiative, Rhode Island's dual-eligible demonstration program
- Flexibility in Long Term Care Facility Bed Licensing
- Integration of Public Health Initiatives

Overall Program Strategy

Commenters also spoke to the general program strategy and vision as outlined in the roadmap. Frequent comments focused on the following topics:

- *Timeline and milestone expectations* – Many commenters expressed concern at the speed with which the state was proposing to implement the program.
- *Flexibility* – A number of comments spoke with varying degrees of support for the granting of flexibility from the state to MCOs and from MCOs to AEs.
- *Consumer Choice and Access* – Commenters highlighted the need to ensure the protection of consumer choice in the Medicaid program and to protect access to services given the preferred network structure that some AEs may consider developing.

Program Operational Details

Commenters provided significant feedback on operational details that EOHHS will develop further through upcoming guidance documents. Specific areas of feedback included:

- AE Certification
- Alternative Payment Methodologies
- Attribution
- Delegation of Responsibilities
- Incentive Payment Program
- Quality Scorecard
- Reporting and Data Sharing
- Social Service Integration

- Specialized AEs (LTSS)

3. Appendix C: Roadmap Required Components

| | STC Required Elements of Roadmap | Where Addressed |
|---|---|--|
| A | (a) Specify that a menu of metrics and measures that will be used by the MCOs to assess the performance of the AEs through the activities of the AE subcontractors shall be defined in the APM guidance document. | <i>Section IX. Program Monitoring, Reporting, & Evaluation Plan</i> <ul style="list-style-type: none"> Page 35, 1st paragraph |
| B | (b) Include guidelines requiring AEs to develop individual AE Health System Transformation Project Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance; | <i>Section VIII. Medicaid Incentive Program (MIIP)</i> <i>Section C. Implementation & Oversight</i> <ul style="list-style-type: none"> Page 31, in bullets under paragraph titled 1. Specifications |
| C | (c) Report to CMS any issues within the AEs that are impacting the AE's ability to meet the measures/metrics, or any negative impacts to enrollee access, quality of care or beneficiary rights. The state, working with the MCOs shall monitor statewide AE performance, trends, and emerging issues within and among AEs on a monthly basis, and provide reports to CMS on a quarterly basis. | <i>Section IX. Program Monitoring, Reporting, & Evaluation Plan</i> <ul style="list-style-type: none"> Page 36, in paragraph titled 2. In-Person Meetings with MCOs |
| D | (d) Provide minimum standards for the process by which EOHHS seek public input in the development of the AE Certification Standards; | <i>Section VI. AE Certification Requirements</i> <ul style="list-style-type: none"> Page 18, 1st and 2nd paragraphs |
| E | (e) Specify a State review process and criteria to evaluate each AE's individual Health System Transformation Project Plan and develop its recommendation for approval or disapproval; | <i>Section VIII. Medicaid Incentive Program (MIIP)</i> <i>Section C. Implementation & Oversight</i> <ul style="list-style-type: none"> Page 31-32, in paragraph titled 2. MCO Review Committee |
| F | (f) Describe, and specify the role and function, of a standardized, AE-specific application to be submitted to the State on an annual basis for participation in the AE Incentive Program, as well as any data books or reports that AEs may be required to submit to report baseline information or substantiate progress; | <i>Section VI. AE Certification Requirements</i> <ul style="list-style-type: none"> Page 18, 1st paragraph <i>Section IX: Program Monitoring, Reporting, & Evaluation Plan</i> <ul style="list-style-type: none"> Page 35-36, in paragraph beginning with "Pertaining more directly to AE program operations..." |

| | | |
|---|--|--|
| G | (g) Specify that AEs must submit semi-annual reports to the MCO using a standardized reporting form to document its progress in achieving quality and cost objectives, that would entitle the AE to qualify to receive Health System Transformation Project Payments; | <p><i>Section VIII. Medicaid Incentive Program (MIIP)</i></p> <p><i>Section C. Implementation & Oversight</i></p> <ul style="list-style-type: none"> • Page 32, in paragraph titled <i>3. Required Structure for Implementation</i>, 4th bullet |
| H | (h) Specify that each MCO must contract with Certified AEs in accordance with state defined APM guidance and state defined AE Incentive Program guidance. The APM guidance will include a Total Cost of Care (TCOC) methodology and quality benchmarks. For specialized AEs where TCOC methodologies may not be appropriate, other APM models will be specified. Describe the process for the state to review and approve each MCO's APM methodologies and associated quality gates to ensure compliance with the standards and for CMS review of the APM guidance as stated in STC 47(e). | <p><i>Section VII: Alternative Payment Methodologies</i></p> <ul style="list-style-type: none"> • Page 23, in paragraph titled AE Attributable Populations |
| I | (i) Specify the role and function of the AE Incentive Program guidance to specify the methodology MCOs must use to determine the total annual amount of Health System Transformation Project incentive payments each participating AE may be eligible to receive during implementation. Such determinations described within the APM guidance document shall be associated with the specific activities and metrics selected of each AE, such that the amount of incentive payment is commensurate with the value and level of effort required; these elements are included in the AE incentive plans referenced in STC 47 (f). Each year, the state will submit an updated APM guidance document, including APM Program guidance and the AE Incentive Program Guidance. | <p><i>Section VIII. Medicaid Incentive Program (MIIP)</i></p> <p><i>Section A. Program Structure</i></p> <ul style="list-style-type: none"> • Page 26, in paragraph titled <i>3. Accountable Entity Incentive Pool</i> <p><i>Section VIII. Medicaid Incentive Program (MIIP)</i></p> <p><i>Section C. Implementation & Oversight</i></p> <ul style="list-style-type: none"> • Page 31-32, in paragraph titled <i>2. MCO Review Committee</i>, 3rd bullet • Page 32, in paragraph titled <i>3. Required Structure for Implementation</i>, in 2nd bullet, 4th sub-bullet |
| J | (j) Specify a review process and timeline to evaluate AE progress on its Health System Transformation Project Plan metrics in which the MCO must certify that an AE has met its approved metrics as a condition for the release of | <p><i>Section VIII. Medicaid Incentive Program (MIIP)</i></p> <p><i>Section C. Implementation & Oversight</i></p> <ul style="list-style-type: none"> • Page 32, in paragraph titled <i>3. Required Structure for Implementation</i>, in 3rd bullet |

| | | |
|---|--|---|
| | associated Health System Transformation Project funds to the AE; | |
| K | (k) Specify that AE's failure to fully meet a performance metric under its AE Health System Transformation Project Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment); | <p><i>Section VIII. Medicaid Incentive Program (MIIP)</i></p> <p><i>Section C. Implementation & Oversight</i></p> <ul style="list-style-type: none"> • Page 32-33, in paragraph titled <i>3. Required Structure for Implementation</i>, 5th bullet |
| L | (l) Describe a process by which an AE that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated Health System Transformation Project Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric, | <p><i>Section VIII. Medicaid Incentive Program (MIIP)</i></p> <p><i>Section C. Implementation & Oversight</i></p> <ul style="list-style-type: none"> • Page 32-33, in paragraph titled <i>3. Required Structure for Implementation</i>, 6th bullet |
| M | (m) Include a process that allows for potential AE Health System Transformation Project Plan modification (including possible reclamation, or redistribution, pending State approval) and an identification of circumstances under which a plan modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved; and | <p><i>Section VIII. Medicaid Incentive Program (MIIP)</i></p> <p><i>Section B. Program Spending Guidance</i></p> <ul style="list-style-type: none"> • Page 31, 2nd paragraph |
| N | (n) Include a State process of developing an evaluation of Health System Transformation Project as a component of the draft evaluation design as required by STC 132. | <p><i>Section IX. Program Monitoring, Reporting, & Evaluation Plan</i></p> <ul style="list-style-type: none"> • Page 37, in paragraph titled <i>4. Evaluation Plan</i> |

Attachment O: Accountable Entity- Specific Health Transformation Project Plan
See Attachment N

Attachment P: Claiming Protocol – Other DSHPs

Introduction

The Special Terms and Conditions (STCs) of Rhode Island's Section 1115(a) Demonstration #11-W-00242/1 approved by the Centers for Medicare and Medicaid Services (CMS) on October 20, 2016, provides expenditure authority to Rhode Island (RI) Medicaid for Designated State Health Programs. Accordingly, Rhode Island Medicaid established Designated State Health Programs (DSHPs) to permit Federal Financial Participation (match) claiming for DSHP expenditures that provide or support the provision of health services in Rhode Island.

Under this approval, the following Designated State Health Programs (also termed "Program Group(s)", "Program" or "Agency") were established and are listed below with their respective claiming protocol Attachment:

- Attachment P ("Other DSHPs")
 - Tuberculosis Clinic
 - Center for Acute Infectious Disease Epidemiology
 - Rhode Island Child Audiology Center at the RI School for the Deaf
 - Consumer Assistance Programs
 - Office of the Child Advocate
 - Commission on the Deaf and Hard of Hearing
- Attachment Q
 - Wavemaker Fellowship
- Attachment S
 - Health Workforce Development (RI Public Institutions of Higher Education*)
**Includes Community College of Rhode Island, Rhode Island College, University of Rhode Island*

Through these DSHPs, additional CNOM (Costs Not Otherwise Matchable) activities have been identified for which Federal Financial Participation (FFP) may be claimed. Allowable DSHP claims for each Program are limited to the allowable DSHP costs ("Allowable Costs" or expenditures) incurred for the months of the time period defined by the STCs. Under the STCs, the state cannot begin to claim FFP for any of the DSHPs until the corresponding protocols are approved. Upon CMS approval of each DSHP claiming protocol, the state may claim FFP for the corresponding approved DSHP expenditures beginning with the date these STCs were approved, October 20, 2016.

This document, Attachment P to those STCs, addresses the "Other DSHPs". Separate Protocols are established for the Wavemaker Fellowship DSHP - Attachment Q, and the Health Workforce Development DSHP - Attachment S. This document along with Attachments Q and S are attachments to those STCs and articulate the protocol for determination of DSHP expenditures eligible for FFP, describe the claiming and reporting methods and identify the records required to be maintained to support the STCs relating to the DSHPs.

All claimable DSHP expenditures will be made from the State's general funds and do not include any expenditures that are used to meet any federal maintenance of effort requirements nor to provide match for any other federal purpose or grant. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to non-qualified aliens. To implement this limitation, a reduction of 9 percent of total expenditures of the Tuberculosis Clinic, Center for Acute Infectious Disease and Epidemiology and the Consumer Assistance Program DSHPs will be treated as expended for non-emergency care to non-qualified aliens and eliminated from amounts claimed.

Rhode Island Medicaid will enter into an Interagency Service Agreements (ISA) with each of these Other DSHPs or their parent State agency. Each Agreement will specify what can count as a DSHP expenditure, documentation requirements for the expenditure, and an assurance that the DSHP gives RI Medicaid authority to submit the claim based on their documented, eligible DSHP expenditures. In accordance with the ISA, each DSHP or administering Agency will provide verification that the DSHP eligible expenses are accurate and complete and are based on the instructions provided in this claiming protocol.

DSHP Authority

The relevant authorizing language in the STCs (STC 84) states that Rhode Island may claim FFP for expenditures for each of the Other DSHPs follows:

- 1) **“Tuberculosis Clinic- Department of Health** - the state may claim FFP for expenditures otherwise uncompensated by Medicaid or third party payers that are incurred by the Tuberculosis Clinic within the Rhode Island Department of Health but are attributable to Medicaid and other low-income patients. The Tuberculosis Clinic is responsible for TB surveillance to detect cases and assures the availability of TB Specialty Clinical Services (adult and pediatric clinical services) to improve health outcomes and increase the efficiency and quality of care to all Rhode Island citizens.
- 2) **Rhode Island Child Audiology Center- RI school for the deaf** - the state may claim FFP for expenditures otherwise uncompensated by Medicaid or third party payers that are incurred by the Rhode Island Child Audiology Center- RI School for the Deaf but are attributable to Medicaid and other low-income patients. The Audiology Center provides statewide hearing screening for children at all Rhode Island schools and will provide further diagnostic testing and referral for treatment for any child who screens at-risk for hearing loss.
- 3) **Center for Acute Infectious Disease Epidemiology- RI Department of Health** - the state may claim FFP for expenditures otherwise uncompensated by Medicaid or third party payers that are incurred by the state's Center for Acute Infectious Disease Epidemiology within the Rhode Island Department of Health and are attributable to Medicaid and other low income patients. This program conducts surveillance, clinical case review and disease investigation for reportable infectious diseases to case manage, investigate and track diseases to reduce and control infectious diseases.

- 4) **Consumer Assistance Programs- Executive Office of Health and Human Services** - the state may claim FFP for expenditures related to the two specific programs within the Consumer Assistance Programs - Executive Office of Health and Human Services:
- i) The Office of the Child Advocates (OCA) is an independent state agency responsible for protecting the legal rights and interests of all children in state care. These rights include, but are not limited to, a child's right to healthcare and education.
 - ii) The Commission on the Deaf and Hard of Hearing (CDHH) coordinates, and provides services committed to promoting an environment in which the Deaf and Hard of Hearing in Rhode Island are afforded equal opportunity in all aspects of their lives".

The following section discusses the expenditure preparation, validation and submission procedures.

Expenditures Claimable for FFP

The Allowable Costs for each DSHP under this protocol is determined by each Agency identifying the allowable total costs (expenditures) recorded by the Agency in the State's Accounting System (RIFANS) during the respective fiscal quarter being reported.

Each Agency uses Rhode Island's accounting system for all its accounting transactions which classifies expenditures using State designated transaction coding, procedures and internal controls and approval processes. The chart of accounts structure in RIFANS includes these primary coding structure elements which are relevant for Allowable Cost reporting: agency, fund, transaction date, expense account category, expense amount and description. Transactions in the system require these coding structures to store, process, and report out expenditures for all programs, including the programs to be claimed under these DSHPs.

All expenditures to be claimed under this Protocol are recorded in the State's financial statements which are audited annually by the Rhode Island Auditor General and included each year in the State's Comprehensive Annual Financial Report (CAFR). The allowable costs will be guided by the standards defined in the Office of Management and Budget (OMB) circular, effective December 26, 2013, "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards", defined at 2CFR 200.402, as amended from time to time (also called "Super-circular"). Additionally as a State Agency, all transactions are recorded in the accordance with generally accepted accounting principles (GAAP) as promulgated by the Governmental Accounting Standards Board.

Using the State's accounting system, the Agency will identify the allowable expenditures, as described above, incurred in a quarter commencing with the date of CMS approval of the STCs (October 20, 2016) and will complete and submit the "DSHP Allowable Cost Report" (**Exhibit B**) to EOHHS no later than 40 calendar days after the end of the quarter in which the expenditures occur. All expenses claimed under this DSHP protocol must be auditable and comply with all State approval and processing procedures and be properly authorized, documented, and recorded in the State accounting system. All data included in **Exhibit B** will be subject to audit and the DSHP will retain sufficient documentation for each expenditure to withstand audit.

Expenditure Verification

Along with the completed “DSHP Allowable Cost Report”, the Agency will provide an “Expenditure Verification” (EV) (**Exhibit A**) to this Claiming Protocol attesting that the reported expenditures are accurate and in accordance with this Claiming Protocol, include only allowable costs and are not used as match or MOE (Maintenance of Effort) for any federal grants nor for any federal program or grant.

Expenditure Substantiation

The Agency will provide reports of expenditures made as required by this claiming protocol and provide reports, procedure narratives and such other documentation as requested by EOHHS as needed for audit or such other compliance or documentation purposes as arise from time to time. If EOHHS requests it, the Agency shall provide detailed records supporting the expenditure statement including records that document verified expenditures, and to the extent any personally identifiable records are relevant, provision of such records is subject to and shall be in conformity with applicable provisions of the Family Educational Rights and Privacy Act (FERPA) and/or the Health Insurance Portability and Accountability Act (HIPAA).

Claiming for DSHP Funds

Upon receipt of **Exhibit A** with **Exhibit B** from the Agency, EOHHS shall approve or reject any such expenditure statement, or request additional information within 10 business days after receipt by EOHHS. EOHHS shall provide the Agency with a written explanation if any statement is rejected and, if the Agency requests it, agrees to meet with Agency personnel to provide the Agency a reasonable opportunity to understand the basis of the rejection and an opportunity to amend the statement of expenditures to resolve any questions EOHHS has and, if possible, remove any obstacles to inclusion of the expenditures in the State’s expenditure report to CMS.

Provided that EOHHS determines that the Agency expenditures described herein and verified by the Agency would qualify for FFP and satisfy the federal time limits for claiming, EOHHS shall include the amount of such expenditures in its Quarterly Medicaid Assistance Expenditures (“CMS 64”) report for purposes of claiming FFP for those expenditures. In order to provide CMS with timely assurance and support for the DSHP payments, the State will document through the respective quarterly report to CMS the expenditure detail supporting the request for DSHP payments.

Changes to Previously Claimed Amounts

EOHHS shall inform the Agency of any communication and provide the Agency with a copy of any letter or other communication from state or federal officials or staff relating to questions, audits, review, request for information, deferral, recoupment or disallowance of FFP for expenditures verified by the Agency.

The Agency shall inform EOHHS of any communication and provide EOHHS with a copy of any letter or other communication from state or federal officials or staff relating to questions, audits, review, request for information, deferral, recoupment or disallowance of FFP for expenditures verified by the Agency pursuant to this Protocol.

RI EOHHS reserves the right to submit DSHP qualifying and allowable expenditures received from the Agency after 40 days for FFP claiming as long as the expenditures were incurred no more than 2 years prior to the date of FFP claim, in accordance with the federal regulation at 45 CFR Part 95, Subpart A.

EXHIBIT A: EXPENDITURE VERIFICATION (EV) FORM

(See next page for form; MS Word version imbedded here for use)



Exhibit A - Other
DSHP EV draft_04.17

The State of Rhode Island and Providence Plantations Medicaid Agency (EOHHS) requires certain information to enable EOHHS to recognize costs incurred for services rendered for Designated State Health Program (DSHP) as allowable expenditures. The Expenditure Verification (EV) form provides EOHHS with verification of expenditures by the HSTP which will allow EOHHS to draw federal matching funds.

This mandatory form will be retained as part of the fiscal documentation for EOHHS. The completed and signed EV form must be submitted to the attention of the HSTP Program Director by FAX to (401) 462-4652; by email to paul.loberti@ohhs.ri.gov or mailed to:

Paul G. Loberti, MPH
RI EOHHS Administrator for Medical Services & HSTP Program Director
Hazard Building
74 West Road
Cranston, RI 02920

SECTION I – AGENCY INFORMATION

| | |
|--------------------------------|--|
| Report Period Number | Federal Provider Identification |
|--------------------------------|--|

Name and Address – Agency

| |
|--|
| |
|--|

SECTION II - VERIFICATION

This is to verify that:

- I am authorized to review, sign, and submit this form on behalf of this Rhode Island Agency.
- This DSHP expended \$ _____ in general funds for this eligible Rhode Island Designated State Health Program (DSHP), as approved by CMS October 20, 2016 in the 11-W-00242/1 amendment to Rhode Island's section 1115 Demonstration Waiver. The attached Exhibit B is the Allowable Cost report showing the expenditures identified for this approved DSHP program during this report period.
- The report period for this verification is: _____ (mm-dd-yy), through _____ (mm-dd-yy).
- These expenditures do not include costs used to meet federal maintenance of effort requirements nor to provide match for any other federal purpose or grant.
- Records documenting these expenditures are available for audit by EOHHS.
- I have reviewed the foregoing and verify that the information reported is true and correct to the best of my knowledge and belief.

SECTION III – SIGNATURE

| | |
|---|---|
| SIGNATURE – Authorized Representative | Date Signed |
| Name – Authorized Representative (print) | Telephone Number – Authorized Representative |
| | |
| Title – Authorized Representative | Email Address – Authorized Representative |
| | |

EXHIBIT B: DSHP ALLOWABLE COST REPORT

(See below for example of forms Exhibit B; MS Excel version imbedded here for use)



Exhibit B - Other
DSHP Allowable Cos



DSHP Allowable Cost Reporting

DSHP Name:

Fiscal Quarter:

Agency Administering DSHP, if different from DSHP

| (a) | (b) | (c) | (d) | (e) |
|-------------|----------------------------------|------------------------------------|----------------------------------|----------------------------|
| Line # | Expense Description | Total Allowable Costs this quarter | Prior Cumulative Allowable Costs | Cumulative Allowable Costs |
| 1 | Salaries | - | - | - |
| 2 | Benefits | - | - | - |
| 3 | Operating, Supplies and Expenses | - | - | - |
| 4 | Contractual Services | - | - | - |
| 5 | List, if necessary | - | - | - |
| 6 | List, if necessary | - | - | - |
| 7 | List, if necessary | - | - | - |
| 8 | List, if necessary | - | - | - |
| 9 | List, if necessary | - | - | - |
| 10 | List, if necessary | - | - | - |
| Total Costs | | \$ - | \$ - | \$ - |

EXHIBIT B

Instructions

Enter Agency/ Name

Enter Fiscal Quarter to which report applies

Enter Name of Agency Administering DSHP, if not DSH

In Column '(c) enter the \$ amount of the respective expense from RIFANS for the quarter.

In Column (d), enter the previously submitted cumulative costs.

Column '(e) will automatically populate.

Provide additional supporting detail as and when required by EOHHS under this Claiming Protocol.

Attachment Q: Wavemaker Methodology and Claiming Protocol

Introduction

The Special Terms and Conditions (STCs) of Rhode Island's Section 1115(a) Demonstration #11-W-00242/1 approved by the Centers for Medicare and Medicaid Services (CMS) on October 20, 2016, approved expenditure authority to Rhode Island (RI) Medicaid for Designated State Health Programs. Accordingly, Rhode Island Medicaid established Designated State Health Programs (DSHPs) to permit Federal Financial Participation claiming for DSHP expenditures that provide or support the provision of health services in Rhode Island.

Under this approval, the following Designated State Health Programs (also termed "Program Group(s)", "Program" or "Agency") were established and are listed below with their respective claiming protocol Attachment:

- Attachment Q
 - Wavemaker Fellowship
- Attachment P ("Other DSHPs")
 - Tuberculosis Clinic
 - Center for Acute Infectious Disease Epidemiology
 - Rhode Island Child Audiology Center at the RI School for the Deaf
 - Consumer Assistance Programs
 - Office of the Child Advocate
 - Commission on the Deaf and Hard of Hearing
- Attachment S
 - Health Workforce Development (RI Public Institutions of Higher Education*)
**Includes Community College of Rhode Island, Rhode Island College, University of Rhode Island*

Through these DSHPs, additional CNOM (Costs Not Otherwise Matchable) activities have been identified for which Federal Financial Participation ("FFP" or "match") may be claimed. Allowable DSHP claims for each Program are limited to the allowable DSHP costs ("Allowable Costs" or expenditures) incurred for the months of the time period defined by the STCs. Under the STCs, the state cannot begin to claim FFP for any of the DSHPs until the corresponding protocols are approved. Upon CMS approval of each DSHP claiming protocol, the state may claim FFP for the corresponding approved DSHP expenditures beginning with the date the STCs were approved, October 20, 2016.

This document, Attachment Q to those STCs, addresses the "Wavemaker Fellowship" sponsored by the Rhode Island Commerce Corporation (Commerce, Corporation or Agency) and established under RI General Law 42.64.26. As a quasi-public organization, the Rhode Island Commerce Corporation is a component unit of the State of Rhode Island and funded through an appropriation from the Rhode Island General Assembly as well as through bonds issued by the Corporation, donations and fees for services. Separate Protocols are established for the Other DSHPs, Attachment P, and the Health Workforce Development DSHP, Attachment S. This document along with Attachments P and S are

attachments to those STCs and articulate the protocol for determination of DSHP expenditures eligible for FFP, describe the claiming and reporting methods and identify the records required to be maintained to support the STCs relating to the DSHPs.

All claimable DSHP expenditures will be made from the State's general funds and do not include any expenditures that are used to meet any federal maintenance of effort requirements nor to provide match for any other federal purpose or grant.

Rhode Island Medicaid will enter into an Interagency Service Agreements (ISA) with the Commerce Corporation. The Agreement will specify what can count as a DSHP expenditure, documentation requirements for the expenditure, and an assurance that the DSHP gives RI Medicaid authority to submit the claim based on their documented, eligible DSHP expenditures. In accordance with the ISA, the Agency will provide verification that the DSHP eligible expenses are accurate and complete and are based on the instructions provided in this claiming protocol.

DSHP Authority

The relevant authorizing language in the STCs (STC 84) states that Rhode Island "may claim FFP for expenditures under the Wavemaker Program. The Wavemaker Fellowship is a state-funded loan repayment program. The Wavemaker Fellowship will allow for graduates working in the healthcare settings to serve and make an impact on the health care of Medicaid beneficiaries".

The following describes the Wavemaker Fellowship program included in this claiming protocol.

Program Background

The Wavemaker Fellowship provides a financial incentive for recent college graduates to work in RI by defraying student loan payments for up to four years for graduates pursuing careers and employed in positions in Rhode Island in areas of health care, medicine, medical device technology, natural or environmental sciences, computer, information or software technology; advanced mathematics, finance; engineering, industrial or other commercial design fields.

To be eligible, an applicant for the Fellowship must have incurred student loan debt during the completion of an associate's, bachelor's, or graduate degree and must work in Rhode Island in a designated field. A fellowship committee convened by the Corporation selects fellowship recipients from among the qualified applicants using a competitive, merit-based process.

Fellowship awardees receive an annual award for up to four years in the form of a cash payment or a redeemable tax credit against their Rhode Island income tax to defray the cost of student loan repayments. The award will equal the fellow's annual loan repayment expenses subject to the following caps: \$6,000 for a fellow with a graduate degree, \$4,000 for a fellow with a bachelor's degree, and \$1,000 for a fellow with an associate's degree. "Eligible Expenses" means annual higher education loan repayment expenses, including, without limitation, principal, interest and fees, as may be applicable, incurred by an eligible graduate and which the eligible graduate is obligated to repay for attendance at a postsecondary institution of higher learning. Notwithstanding the foregoing, late

fees or other penalties for late payment shall not constitute Eligible Expenses”. The Fellowship is awarded and paid by the Rhode Island Commerce Corporation.

The application period is typically in the second quarter of the calendar year, with awardees named in the third quarter, and award payments made only after a 12-month qualifying service period is demonstrated. These award payments are typically made in the fourth quarter of the following calendar year. For example, an awardee named in June 2017 receives the payment/credit in October 2018. That is, the award is realized (paid) only after an individual actually works for a full year in a qualifying position in RI.

The full text of the Wavemaker Fellowship regulations and the enacted governing legislation can be found at <http://commerceri.com/finance-business/taxes-incentives/wavemaker-fellowship/>.

Expenditures Claimable for FFP

Using the Corporation’s accounting system, the Corporation will identify the payments made to the certified awardees (the “Allowable Expenditures”) as described above, incurred in a year commencing with the date of CMS approval of the STCs (October 20, 2016) and will complete and submit the “Wavemaker Allowable Expenditure Report” template in **Exhibit B** to EOHHS no later than 40 calendar days after the end of the quarter in which the payment occurs.

In the “Wavemaker Allowable Expenditure Report”, the Corporation will submit a list of those Fellows receiving the award for which FFP will be claimed utilizing the Corporation’s database which tracks Fellowship awards, job, and employer information.

The Commerce Corporation validates and authorizes the payment/credit of an award by identifying the number of participating graduates and loan repayment amounts as follows:

- A. Within six (6) months after the end of each Award year, a Fellowship Recipient submits a certification to the Commerce Corporation certifying:
 - (1) The amount the Fellowship Recipient has actually incurred and paid in Eligible Expenses;
 - (2) The Fellowship Recipient continues to meet the eligibility requirements of employment with an “eligible Rhode Island based employer”, as defined in the Wavemaker regulations, throughout the year of employment;
 - (3) The amount sought in Fellowship Award does not exceed the original loan amount; and,
 - (4) The Fellowship Recipient is current on his or her student loan repayment obligations.
- B. Upon a review of the submission and determination that the Fellowship Recipient has met the requirements specified in the Award Letter, the Corporation will issue an Annual Certification to the Fellowship Recipient providing entitlement to the issuance of a Tax Credit Certificate for a specified year in an amount determined pursuant to the Award Letter;
- C. The Awardee must make a one-time election to receive the award in cash or as a tax credit.

Expenditure Verification

Along with the completed “Wavemaker Allowable Expenditure Report” the Corporation will provide an Expenditure Verification form (**Exhibit A** to this Claiming Protocol) attesting that the reported expenditures are accurate in accordance with this Claiming Protocol, include only Allowable Expenditures, are not used as match or MOE (Maintenance of Effort) for any federal grants, and are funded by the State’s annual appropriation for the Wavemaker program permitted by this Claiming Protocol.

Expenditure Substantiation

The Agency will provide reports of expenditures made as required by this claiming protocol and provide reports, procedure narratives and such other documentation as requested by EOHHS as needed for audit or such other compliance or documentation purposes as arise from time to time. If EOHHS requests it, the Agency shall provide detailed records supporting the expenditure statement including records that document verified expenditures, and to the extent any personally identifiable records are relevant, provision of such records is subject to and shall be in conformity with applicable provisions of the Family Educational Rights and Privacy Act (FERPA) and/or the Health Insurance Portability and Accountability Act (HIPAA).

All expenditures to be claimed under this Protocol are included in the Corporation’s annual financial statements audited by an external public accounting firm which are included in the State’s Comprehensive Annual Financial Report (CAFR) audited annually by the Rhode Island Auditor General. Additionally as a State Agency, all transactions are recorded in the accordance with generally accepted accounting principles (GAAP) as promulgated by the Governmental Accounting Standards Board.

Claiming for DSHP Funds

Upon receipt of **Exhibit A** with **Exhibit B** from the Corporation, EOHHS will approve or reject any such Expenditure Verification statement, or request additional information within 10 business days after receipt by EOHHS. EOHHS shall provide the Corporation with a written explanation if any statement is rejected and, if the Corporation requests it, agrees to meet with Corporation personnel to provide a reasonable opportunity to understand the basis of the rejection and an opportunity to amend the statement of expenditures to resolve any questions EOHHS has and, if possible, remove any obstacles to inclusion of the expenditures in the State’s expenditure report to CMS.

Provided that EOHHS determines that the Corporation’s expenditures described herein and verified by the Corporation would qualify for FFP and satisfy the federal time limits for claiming, EOHHS shall include the amount of such expenditures in its Quarterly Medicaid Assistance Expenditures (“CMS 64”) report for purposes of claiming FFP for those expenditures in the quarter in which the claim is made. In order to provide CMS with timely assurance and support for the DSHP payments, the State will document through the respective quarterly report to CMS the expenditure detail supporting the request for DSHP payments.

RI EOHHS reserves the right to submit DSHP qualifying and allowable expenditures received from the Corporation after 40 days for FFP claiming as long as the expenditures were incurred no more than 2 years prior to the date of FFP claim, in accordance with the federal regulation at 45 CFR Part 95, Subpart A.

Changes to Previously Claimed Amounts

EOHHS shall inform the Commerce Corporation of any communication and provide the Corporation with a copy of any letter or other communication from state or federal officials or staff relating to questions, audits, review, request for information, deferral, recoupment or disallowance of FFP for expenditures certified by the Corporation.

The Commerce Corporation shall inform EOHHS of any communication and provide EOHHS with a copy of any letter or other communication from state or federal officials or staff relating to questions, audits, review, request for information, deferral, recoupment or disallowance of FFP for expenditures certified by the Corporation pursuant to this Protocol.

Wavemaker Fellowship Workforce Methodology

The Wavemaker Fellowship promotes HSTP goals by providing a financial incentive for graduates to pursue a health care career in Rhode Island. The Wavemaker Fellowship promotes careers in health care by providing loan repayment for graduates working in a Rhode Island healthcare setting that serves Medicaid enrollees.

The work under the Wavemaker DSHP will be closely integrated and aligned with the goals and strategies of the larger Health Care Workforce Development effort (Attachment R to the STCs). In particular, funds from the Wavemaker DSHP will be used to support Workforce Development efforts, with a primary focus on recruiting graduates to work in RI by increasing enrollment of entry level health professional graduates into the Wavemaker Program. This will be combined with a broad effort to recruit and retain health professionals in RI through education and recruitment about Wavemaker at colleges and universities as well as Medicaid providers.

EOHHS and the Commerce Corporation, with the support of the overall Workforce Development effort (Attachment R), will work with the three state colleges/universities as well as private colleges/universities to assist in identifying graduates who may qualify for the Wavemaker opportunity and with provider organizations that serve Medicaid enrollees and employ healthcare graduates. This will maximize the Wavemaker loan repayment opportunity in order to attract new hires to RI's health care workforce, in particular to positions where there is an unmet staffing need.

The Wavemaker DSHP will assist in the accomplishment of the following goal and objectives of the larger Health Care Workforce Development effort as stated in Attachment R.

Goal: Healthcare Career Pathways: Skills That Matter For Jobs That Pay: Prepare Rhode Islanders from culturally and linguistically diverse backgrounds for existing and emerging good jobs and careers in healthcare through expanded career awareness, job training and education, and advancement opportunities.

- Support the Entry-Level Workforce through improving recruitment, retention, and career advancement: the increase in funding will allow the Corporation to expand recruiting efforts to those in the healthcare professions thereby increasing enrollment of health care professions graduates in the Wavemaker program;

- Increase the cultural, ethnic, and linguistic diversity of licensed health professionals by recruiting an increasingly diverse group of health care graduates into the Wavemaker Program through the targeted recruiting efforts;
- Address Provider Shortages: Remediate shortages among certain health professions through the targeted recruitment efforts into the Wavemaker Program targeting the newly graduating health professionals to work in areas of health care professional shortage.

The State will follow the methodology above which will ensure that funds generated as a result of Wavemaker DSHP claiming will improve access and quality of services to the Medicaid population.

Annual Reporting

Beginning January 31, 2018, and annually thereafter, to show reinvestment in Health Care workforce, the Corporation will provide historical comparative data for the most recent Fellowship awards from the Corporation's database which will include a:

- List of Fellowship awards with employer.
- List of Fellowship awardees who have fulfilled their annual work commitment by working with a Health Care (Medicaid) provider serving Medicaid members and a description of the specific health care/medical job (job placement and employer information) in RI for each Health Care Fellowship awarded and paid.

Updates will be provided quarterly, as available.

Exhibit A: Expenditure Verification (EV) Form

(See next page for form; MS Word version imbedded here for use)



Exhibit A -
Wavemaker EV draft



Designated State Health Program EXPENDITURE VERIFICATION

Exhibit A

The State of Rhode Island and Providence Plantations Medicaid Agency (EOHHS) requires certain information to enable EOHHS to recognize expenditures incurred for Designated State Health Program (DSHP) as allowable expenditures. The Expenditure Verification (EV) form provides EOHHS with verification of expenditures by the Agency which will allow EOHHS to draw federal matching funds.

This mandatory form will be retained as part of the fiscal documentation for EOHHS. The completed and signed EV form must be submitted to the attention of the HSTP Program Director by FAX to (401) 462-4652; by email to paul.loberti@ohhs.ri.gov or mailed to:

Paul G. Loberti, MPH
RI EOHHS Administrator for Medical Services & HSTP Program Director
Hazard Building
74 West Road
Cranston, RI 02920

SECTION I – AGENCY INFORMATION

Report Period

Identification Number

Federal Provider

Name and Address – Agency

SECTION II - VERIFICATION

This is to verify that:

- I am authorized to review, sign, and submit this form on behalf of this Rhode Island Agency.
- This Agency recorded \$ _____ in Wavemaker Fellowship awards for this Rhode Island Designated State Health Programs (DSHP), as approved by CMS October 20, 2016 in the 11-W-00242/1 amendment to Rhode Island's section 1115 Demonstration Waiver. Attached in Exhibit B, is the report showing the expenditures identified for the approved DSHP program.
- The report period for this verification is: _____ (mm-dd-yy), through _____ (mm-dd-yy).
- These expenditures do not include costs used to meet federal maintenance of effort requirements nor to provide match for any other federal purpose or grant.
- Records documenting these Fellowship awards are available for audit by EOHHS.
- I have reviewed the foregoing and verify that the information reported is true and correct to the best of my knowledge and belief.

SECTION III – SIGNATURE

SIGNATURE – Authorized Representative

Date Signed

Name – Authorized Representative (print)
Representative

Telephone Number – Authorized

Title – Authorized Representative

Email Address – Authorized Representative

Exhibit B: Wavemaker Allowable Expenditure Report

(See below for example of form; MS Excel version imbedded here for use)

Exhibit B -
Wavemaker Expendi**Wavemaker Fellowship Expenditure Report**

Complete the table below of totals of Wavemaker Fellowship expenditures for the period reported.

Expenditures for Period: _____

| (a) | (b) | (c) | (d) | (e) |
|---|--------------------------------|----------|-----------|----------------------|
| Line # | Awardee Name | Employer | Job Title | \$ Award Expenditure |
| 1 | (First Name, Last Initial) | | | |
| 2 | (First Name, Last Initial) | | | |
| 3 | (First Name, Last Initial) | | | |
| 4 | (First Name, Last Initial) | | | |
| 5 | (First Name, Last Initial) | | | |
| 6 | (First Name, Last Initial) | | | |
| 7 | (First Name, Last Initial) | | | |
| 8 | (First Name, Last Initial) | | | |
| 9 | (First Name, Last Initial) | | | |
| 10 | Insert as many lines as needed | | | |
| Total Fellowship Expenditure for the Period | | | | \$ - |

| Column | Instructions |
|--------|--|
| (b) | Insert the Awardee's name, for privacy purposes provide only First Name and Last Initial. Commerce will retain the detail by full name for audit purposes and if requested by EOHHS. |
| (c) | Insert the name of the Awardee's Employer. |
| (d) | Insert the Awardee's Job Title. |
| (e) | Insert the total dollar amount of the Fellowship expenditure to the Awardee for the period. |

Attachment R: Health Workforce Development Protocol

Introduction

The Special Terms and Conditions (STCs) of Rhode Island's Section 1115(a) Demonstration #11-W-00242/1 approved by the Centers for Medicare and Medicaid Services (CMS) on October 20, 2016, provides expenditure authority to Rhode Island (RI) Medicaid for Designated State Health Programs. Accordingly, Rhode Island established a Health Workforce Development (HWD) Designated State Health Program (DSHP) enabling Rhode Island to promote improved access and quality of care for Medicaid beneficiaries in the State by supporting the education and training of the health care workforce. Specifically, STC 85 states "to ensure that DSHP funds promote the development of workforce training to benefit the Medicaid population and improve access, the State shall commit to implementing the Health Workforce Development Methodology Protocol that will be **Attachment R**".

This document is **Attachment R** to those STCs. The methodology described herein includes: a) the planning efforts Rhode Island has undertaken for workforce development; b) the State, higher education and provider collaboration efforts that have occurred to identify the current environment, needs for the workforce, and plans for continued collaboration; c) the workforce development strategies resulting from the analysis of the previous collaboration efforts; and, d) an outline of the implementation plan the State has defined to achieve the workforce development improvements.

I. Planning and Collaboration

On February 26, 2015, Governor Gina Raimondo issued Executive Order 15-08, establishing the "Working Group to Reinvent Medicaid." In July 2015, the Working Group delivered a multi-year plan for the transformation of the Rhode Island Medicaid program, *"towards a system that pays for the outcomes and quality of care Rhode Islanders deserve, and that addresses the complex medical and social needs critical to achieving improved health status."* Working with partners from the health care sector, the advocacy community, the business community at large, the Executive Office of Health and Human Services (EOHHS) laid out a model for a reinvented publicly financed health care system in Rhode Island based on the following principles:

- Pay for value, not for volume
- Coordinate physical, behavioral, and long-term health care
- Rebalance the delivery system away from high-cost settings
- Promote efficiency, transparency, and flexibility

None of these changes in healthcare are possible without a transformed workforce, with the right workers with the right skills, in the right place, at the right time. Recognizing this need, RI Medicaid under the Executive Office for Health and Human Services (EOHHS) launched a Healthcare Workforce Transformation ("HWT" also "HWD" (Healthcare Workforce Development) planning process in June, 2016, to assess Rhode Island's current and projected healthcare workforce needs and educational capacity, and to identify priorities and strategies to align healthcare workforce

education and training programs with the objectives of the State's Health System Transformation Program (HSTP).

The HWT process involved the active participation of more than two-hundred fifty (250) healthcare partners representing providers, educators, policy-makers, payers, community-based organizations, advocates, professional associations and labor organizations. This process included regular meetings of a twenty person Advisory Committee, three large stakeholder meetings, thirty one-on-one interviews, and seven small group discussions on a variety of health focus areas including primary care, behavioral health, social determinants and cultural competence, health information technology, home and community-based care, chronic disease, and oral health. The focus of these efforts was to identify the knowledge, skills, training, and experience that will be needed by the current and future healthcare workforce to support health system transformation.

II. Strategies

This initial planning phase of the EOHHS HWT initiative culminated in early May, 2017 with the publication of the EOHHS Healthcare Workforce Transformation Report (Report), which includes data (labor market, education, and licensure), best practices (national and local), a compendium of “transformative” occupations, and an inventory of healthcare workforce development resources in RI. Most importantly, the Report identifies the following priorities and strategies to guide the State’s support for, and development of, the healthcare workforce that RI will need to achieve the goals of the Health System Transformation Project.

1. ***Healthcare Career Pathways: Skills That Matter For Jobs That Pay**

Prepare Rhode Islanders from culturally and linguistically diverse backgrounds for existing and emerging good jobs and careers in healthcare through expanded career awareness, job training and education, and advancement opportunities. **Strategies:**

- ***Support the Entry-Level Workforce:** Improve recruitment, retention, and career advancement.
In order to support RI Medicaid’s goal to rebalance the system away from high-cost settings, skilled and committed in-home care workers (home health aides, personal care aides), that work on the “frontlines” of healthcare become even more essential.
- ***Increase Diversity and Cultural Competence:** Increase the cultural, ethnic, and linguistic diversity of licensed health professionals.
As in much of the United States, Rhode Island’s population has grown more diverse culturally, ethnically, and linguistically. The shift to community-based care, the heightened focus on population health, and the need to reduce health disparities strengthen the case for diversity and cultural competency among healthcare providers. To achieve high quality health outcomes for Medicaid beneficiaries across all populations, a professional workforce that speaks the language and has the trust of multiple communities is critical.
- **Develop Youth Initiatives to Expand the Talent Pipeline:** Increase healthcare career awareness, experiential learning opportunities, and readiness for health professional education.
In order to increase the diversity needed in the workforce, and to ensure that there is a workforce that is sufficient in size and capacities in the near future, pipelines bringing youth into the health workforce are vital.
- **Address Provider Shortages:** Remediate shortages among certain health professions.
If there is an undersupply of practitioners that are critical to transforming the RI Medicaid program, the state may realize a significant barrier in achieving changes in

delivery and payment. Additionally, as the RI Medicaid program transforms, there are roles or occupations in which shortages will emerge if system-changing practices and supporting arrangements depending on these positions and skill sets are implemented. Addressing provider shortages, both current and anticipated, are needed to drive system transformation.

*This goal and strategies are closely aligned with another DSHP Program, the Wavemaker Fellowship Program. The Wavemaker Fellowship provides loan repayment to college/university graduates who are employed by a Rhode Island employer in the health care, medicine, medical device technology, natural or environmental sciences, computer, information or software technology, advanced mathematics, finance; engineering, industrial or other commercial design fields. Although the Wavemaker Fellowship is open to graduates of many academic disciplines, the Wavemaker Fellowship DSHP is restricted to loan repayment to graduates who work in RI in a health care field at a provider which serves the Medicaid population. Funds from the Wavemaker DSHP will be used to support Workforce Development efforts with a primary focus on recruiting graduates to work in RI by increasing enrollment of entry level health professional graduates into the Wavemaker Program. Additional information about the Wavemaker Fellowship DSHP can be found in Attachment Q.

2. Home and Community-Based Care

Increase the capacity of community-based providers to offer culturally-competent care and services in the home and community and reduce unnecessary utilization of high-cost institutional or specialty care.

Strategies:

- Expand Community-based Health Professional Education: Educate and train health professional students to work in home and community-based settings.

As RI Medicaid begins work to rebalance the delivery system away from high-cost settings, health professional education has been identified as an area of need. There is a growing consensus among the practitioners, policy experts, and educators that candidates for health professions are not fully prepared by their classroom training, residencies, or clinicals for community-based practice. To support the goals of Reinventing Medicaid, it is essential that the state educate and train health professional students to work in home and community-based settings.

- Prepare Healthcare Support Occupations for New and Emerging Roles: Prepare healthcare support occupations to work in home and community-based settings.

Creating a workforce prepared for the shift to home and community-based care goes beyond changes in professional education. It also depends on tapping new roles for existing occupations, as well as for new or emerging occupations.

3. Core Concepts of Health System and Practice Transformation

Increase the capacity of the current and future workforce to understand and apply core concepts of health system and practice transformation.

Strategies:

- Prepare Current and Future Health Professionals to Practice Integrated, Team-Based Care: Increase the capacity of health professionals to integrate physical, behavioral, oral health, and long-term care.

To support RI Medicaid’s goal of providing care that coordinates physical, behavioral, and long-term health care, it is necessary to educate the workforce on practice transformation—teaching team members to work collaboratively, apply metrics to monitor outcomes, and improve workflow, among other skills, to improve the quality of care and patient satisfaction.

- Teach Health System Transformation Core Concepts: Educate the healthcare workforce about the significance of value-based payments, care management, social determinants of health, health equity, population health, and data analytics.
Just as learning the skills of integrated, team-based care is a departure from current health professional education, teaching core concepts of transforming health requires new curricula and new lenses for thinking critically and innovatively about health and healthcare. In order to realize the potential of health systems transformation, the healthcare workforce will require new knowledge as well as renewed skills, including an understanding of the “drivers” of system and practice transformation.

III. Implementation

In June, 2017, EOHHS will convene a HWT Summit which is expected to be attended by over two-hundred (200) healthcare partners. The Summit will feature presentations and workshops that will focus on transformative healthcare workforce innovations from throughout the U.S. and Rhode Island that are related to the priorities and strategies outlined in the HWT Report in support of the Health System Transformation Project. The Summit will also serve to launch the implementation phase of EOHHS’s HWT initiative.

Following the Summit, EOHHS will focus on engaging healthcare educators and healthcare providers to address healthcare workforce transformation priorities and health system transformation goals. The HWT development places particular emphasis on partnerships with the Rhode Island Public Institutions of Higher Education – Rhode Island College, Community College of Rhode Island, and the University of Rhode Island (the “IHEs”) as well as the Accountable Entities in Rhode Island (AEs) both of which are referenced in the STCs and critical to the State’s Health System Transformation Project.

Additionally, EOHHS has structured an IHE Steering Committee under the Interagency Service Agreements with each IHE. The Steering Committee will serve to facilitate the linkage between the:

- a) HWT innovative healthcare workforce development strategies and initiatives identified in the HWT Report;
- b) Parties that are poised with readiness and capabilities to carry out the initiatives; and,
- c) Allocation of the IHE DSHP funding for the efforts to implement the innovative healthcare workforce development programs.

The Interagency Service Agreements (ISAs) with the IHEs provide the structure to link the above: a) planning and strategies; b) capabilities and delivery; and, c) funding. The ISAs include defined templates that require written documentation of the proposed initiative(s) with specific goals and deliverables, a project plan and a budget. The procedures established in the ISAs require these templates be submitted to the Steering Committee when the proposal is first presented, updated during the period of the effort, as warranted, and updated when the effort is complete. The Steering Committee meets at least quarterly, reviews all proposals and vets them against the Health Workforce Transformation Priorities and Strategies, makes recommendations to EOHHS for approval, monitors progress and spending on the initiatives, reviews the deliverables against the proposal and recommends EOHHS disburse funding once the initiative is successfully completed.

The clear strategies and direction of the well-vetted and broadly developed HWT Report - in conjunction with the structure, templates, monitoring, and oversight processes of the Steering Committee (as established by the Interagency Service Agreements) - establish a foundation for the successful implementation of innovative HWT activities to support the HSTP.

Attachment S: Claiming Protocol – Health Workforce Development

Introduction

As described in the Special Terms and Conditions (STCs) of Rhode Island's Section 1115(a) Demonstration #11-W-00242/1 approved by the Centers for Medicare and Medicaid Services (CMS) on October 20, 2016, the state may claim FFP to solely support the goals of the State's Health System Transformation Project (HSTP). These STCs provide expenditure authority, which enables Rhode Island to operate its Section 1115 Medicaid Demonstration. Accordingly, Rhode Island established a Designated State Health Program (DSHP) for health workforce training programs and related expenditures to support the program at the University of Rhode Island, Rhode Island College, and the Community College of Rhode Island. This expenditure authority will promote health care objectives that increase efficiency and quality of care through initiatives that transform service delivery networks.

This Health Workforce Development (HWD) DSHP enables Rhode Island ("RI" or "State") to promote improved access and quality of care for Medicaid beneficiaries in the State by supporting the education and training of the health care workforce which results in employment and/or continuing education of employees in settings that provide care and services to Rhode Island Medicaid beneficiaries.

Through these STCs, CMS also approved and Rhode Island established the following Designated State Health Programs (Program Groups or Program) for which FFP can be claimed:

- Wavemaker Fellowship
- Other DSHPs
 - Tuberculosis Clinic at Miriam Hospital
 - Center for Acute Infectious Disease Epidemiology
 - Rhode Island Child Audiology Center
 - Consumer Assistance Programs
 - Office of the Child Advocate
 - Commission on the Deaf and Hard of Hearing

Through these DSHPs, additional CNOM (Costs Not Otherwise Matchable) activities have been identified for which Federal Financial Participation (FFP) may be claimed. Allowable DSHP claims for each Program are limited to the allowable DSHP costs incurred for the months of the time period defined by the STCs (STC 82).

This document addresses the Health Workforce Development DSHP. The other Program Groups are addressed in separate Protocols. (See Attachment Q for Wavemaker and Attachment P for all other DSHPs.) This document along with Attachments P and Q are attachments to those STCs and contain the protocol for determination of the expenditures eligible for FFP, the claiming and reporting methods and identify the records required to be maintained to support the STCs.

As stated in STC 85, “the annual limit the state may claim FFP for workforce training programs is limited to total costs, in accordance with the OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards”. The Office of Management and Budget (OMB) circular effective December 26, 2013, “Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards”, defined at 2 CFR 200.402, as amended from time to time (also called “Super-circular”) provides guidance for determining the allowable costs under this protocol.

All claimable DSHP expenditures will be paid from the IHEs general funds up to the amount of the State’s annual appropriation to each IHE which meet CMS’s conditions as eligible state share in claiming FFP. These expenditures will not include expenditures used to meet any federal maintenance of effort requirements nor to provide match for any other federal purpose or grant.

Rhode Island Medicaid will enter into an Interagency Service Agreements (ISA) with each of the three State colleges/universities. Each Agreement will specify what can count as a DSHP expenditure, documentation requirements of the school, and an assurance that the school gives RI Medicaid authority to submit the claim based on their documented, eligible DSHP expenditures. In accordance with the ISA, each state college/university will provide verification that the DSHP eligible expenses are accurate and complete and are based on the instructions provided to each school in this claiming protocol. The IHE will submit expenditures on a quarterly basis (Exhibit B) and provide an "Expenditure Verification" (EV) form (Exhibit A) signed by the appropriate financial officer at the school, e.g., the Chief Financial Officer or Controller. This EV will be submitted to RI EOHHS for review and validation. These expenditure reports will be a part of the quarterly report to CMS.

After review of the EV document and expenditures, EOHHS will submit the claim to CMS for the verified eligible expenditures. In order to provide CMS with timely assurance and support for the DSHP payments, the State will document through a quarterly report to CMS the expenditure detail supporting the request for DSHP payments. EOHHS will report expenditures under the Other/Misc. line for 64 and 37 report purposes, unless otherwise instructed by CMS. Federal funds will be claimed within two years following the calendar quarter in which the state makes expenditures for the HWD DSHP.

IHE Expenditures

Per STC # 85, “the state may claim FFP for health workforce training programs and related supports at the University of Rhode Island, Rhode Island College and Community College of Rhode Island.” Each IHE will determine the “Allowable Costs” for each “Allowable (Educational) Program” in each accounting quarter, within the terms defined under the STCs, commencing with date of approval of the STCs, October 20, 2016.

Expenditures for DSHP allowable Health Workforce Development (“HWD”) are defined in the STCs as those incurred by Rhode Island’s three public Institutions of Higher Education including the

University of Rhode Island, Rhode Island College and the Community College of Rhode Island to educate and train health professionals in fields to benefit Medicaid beneficiaries. The focus of the discussion following will be on the identification of allowable expenditures incurred by IHEs in training health care professionals.

Expenditures Claimable for FFP

Expenditures incurred for health workforce training and development activities must be allowable, reasonable and allocable and support the goals of the Rhode Island HSTP initiative.

These expenditures, termed “Allowable Costs”) are made on behalf of qualified individuals who graduate from an “Allowable Program” who work for “qualified employers”, where,

- The healthcare workforce is comprised of “qualified individuals (*students*)” and defined as individuals who:
 - Graduate from an allowable program offered by one of the state’s public higher education institutions;
 - Obtain employment in Rhode Island with one or more “qualifying employers” that provide services to Medicaid enrollees (such as hospitals, nursing homes, health centers, and other participating providers); or
 - Individuals who are currently employed by a “qualifying employer” and who complete a continuing education program provided by the state schools designed to increase the ability of the individual to improve the quality, outcomes, and/or cost effectiveness of care and services to Medicaid enrollees;
- “Allowable Programs” are those Programs (degree, certificate, license academic offerings) that train students for a health care profession, are defined for each IHE; programs will vary by IHE depending upon the IHE’s focus, course, degree and educational offerings and will be collectively determined through discussion and analysis between each IHE and EOHHS. “Allowable Programs” may include but are not limited to the following*:
 - Department of Nursing
 - Department of Pharmacy
 - Health Care Administration
 - Allied Health Programs
 - Dental Health Programs
 - Rehabilitative Health Programs

*The IHEs quarterly expenditure reports will be a part of the quarterly report to CMS and will include the specific programs with the respective CIP Codes listed on each school’s report.

- “Qualified employers” are defined as those employers that are Rhode Island Medicaid providers;
- “Allowable Costs” will include:

- The total costs of qualifying health training program at the three state schools, determined in accordance with the OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards” (aka “Super Circular”).
- Adjusted by the “percentage of qualifying students” in each program in the previous year.
- “Total Cost”, defined in the Super-circular, “is the sum of the allowable direct and allocable indirect costs less any applicable credits...such as purchase discounts, rebates or allowances.”
 - “Direct costs” are those costs specifically identified with delivery of a particular objective, in this case, DSHP direct costs are those for delivery of healthcare educational training. DSHP direct costs would include salary and benefits for those who directly deliver the health training programs (e.g., the faculty) and for direct costs necessary to the educational process such as, educational materials, educational subscriptions, guest lecture fees, teaching lab supplies.
 - “Indirect costs” include those costs that are necessary to the educational process and the granting of degrees and certificates but apply to the entire institution that provides the education and training. For purposes of computing “total costs”, each IHE will use the rates approved in their current Indirect Rate Agreement approved by the U. S. Department of Health And Human Services Division of Cost Allocation Services. The rates in these agreements were approved in accordance with the authority of the Office of Management and Budget Circular A-21 (which has been super-ceded by the Super-circular”). The current indirect rate agreements can be found on each IHEs website.

Identification of Allowable Programs

Working in collaboration with the IHE, EOHHS will identify those educational programs that train individuals for a career in the health care professions. Each program will be associated with the **CIP** code for that instructional program as defined by the National Center for Education Statistics Classification of Instructional Programs (**CIP**) which provides a taxonomic scheme that supports the accurate tracking, assessment, and reporting of fields of study and program completions activity. From this taxonomic listing of CIP codes, EOHHS together with the IHEs will identify courses of study that train individuals for a career in the health care professions.

Identification of Allowable Costs

Working in collaboration with EOHHS, the IHE will identify the expenditures associated with those programs of study that meet the requirements for credentials for each of the allowable health care degrees or certificates. The allowable costs will be guided by the standards defined in the OMB’s then current Super-Circular with the IHE’s federally-negotiated and approved indirect rate(s) including on-campus and off-campus rates, as appropriate, utilized to develop Total Costs as defined in #85 of the above referenced STCs.

Determination of Allowable Costs

Each IHE uses an integrated accounting system which classifies expenditures based upon academic departments. Though not all utilize the same system, they accumulate, process, and employ coding structures in similar formats for reporting and audit purposes. The charts of accounts structures have these primary coding structure elements: fund, organization, account, and program. Transactions in

the systems require these coding structures to store, process, and report out expenditures for all programs, including the programs to be claimed under this DSHP.

Through their respective chart of accounts, each IHE records and classifies expenditures for each academic department in the respective accounting systems by functional area. The respective costs of each academic department aggregate to the total costs of the IHEs as presented in their respective Financial Statements.

Additionally, to provide consistency across the IHEs in the determination of Allowable Costs, principles from the National Association of College and University Business Officers (NACUBO) Accounting Principles Council will be utilized in guiding functional reporting of expenses and types of natural expense categories of expense reporting. NACUBO is a membership organization representing more than 2,100 colleges and universities across the country with the mission to advance business practices for higher education institutions. Among the functional reporting categories are: Instructional, Research, Public Service, Academic Support, Student Services Administration, Institutional Support, Operations and Maintenance of Plant, Scholarships and Fellowships, and Auxiliary Operations.

Expenditures to be claimed under this Protocol can be classified as “Instructional” using the NACUBO principles and are included in the respective financial statements of each IHE. The IHE’s financial statements are audited annually and, since each IHE is a component unit of the State of Rhode Island, are included in the State’s Comprehensive Annual Financial Report (CAFR). The IHE will complete the section titled “To be Completed by IHE” on “Allowable Cost Reporting” template at **Exhibit B** of this Attachment for each calendar quarter and will include allowable costs incurred on or after the date of approval of the STCs, October 20, 2016, in accordance with the requirements of this Attachment S.

Reporting of Allowable Costs

Using the IHE’s accounting system, the IHE will identify the allowable costs, as described above by Allowable Program, incurred in a calendar quarter commencing with the date of CMS’ approval of the STCs (October 20, 2016) and will complete and submit the template in **Exhibit B** to EOHHS no later than forty (40) days after the end of each calendar quarter. EOHHS reserves the right to submit DSHP qualifying and allowable expenditures received from an IHE for FFP claiming as long as the expenditures were incurred no more than 2 years prior to the date of FFP claim, in accordance with the federal regulation at 45 CFR Part 95, Subpart A.

Verification of Allowable Costs

Along with the completed Allowable Cost template (**Exhibit B**), the IHE will provide an Expenditure Verification form (EV) (**Exhibit A**) to this Claiming Protocol attesting that the reported expenditures are accurate, are those only for Allowable Programs, include only Allowable Costs and are not used as match or MOE (Maintenance of Effort) for any federal program or grant.

Substantiation of Allowable Costs

For all expenses claimed under this project, the expenses must be auditable and comply with all IHE approval and processing procedures and be properly authorized, documented, and recorded in the respective purchasing, payroll and accounting systems. The IHE will provide reports, procedure

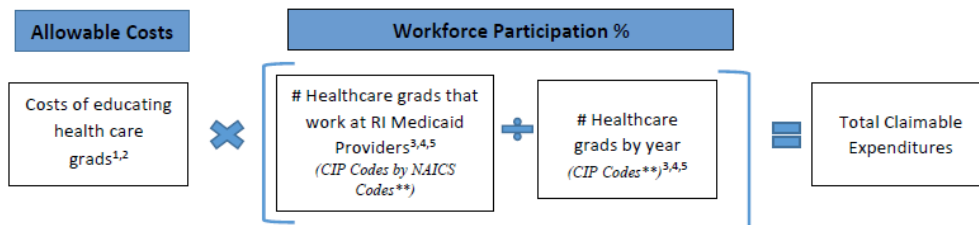
narratives and such other documentation as requested by EOHHS as needed for audit or such other compliance or documentation purposes as arise from time to time.

All labor expenditures must be auditable and be supported by records produced by the IHE's human resource and payroll systems, e.g., payroll register. All salary and benefit expenditures included in **Exhibit B** will be subject to audit and the IHE will retain sufficient documentation for each expenditure to withstand audit.

Workforce Calculation Methodology

The amount of FFP to be claimed under this protocol is determined by:

- A. Each IHE determining the "Allowable Costs" for each "Allowable (Educational) Program" in each accounting quarter; and,
- B. Adjusted by the "percentage of qualifying students" in each program in the previous year as depicted in the following graphic:



(1) Expenditures from general ledger with transaction detail

(2) Wage detail supported by payroll records

(3) Employment from DLT (RI Dept. Labor & Training), Providence Plan, other external agencies

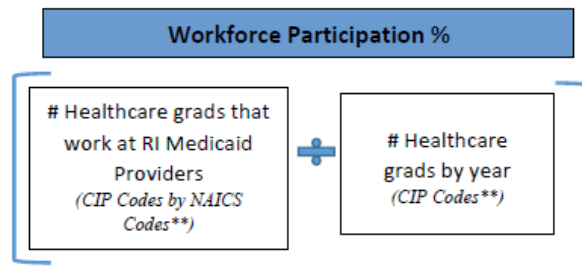
(4) Graduates from RI Office of Postsecondary Commissioner, Providence Plan, other

(5) CIP** codes will be used to match IHE Allowable Programs with those employed in Rhode Island, NAICS** codes will be used to select only those graduates that are employed in a provider that supports Medicaid beneficiaries

** CIP = Classification of Instructional Program

NAICS = North American Industrial Classification

As in the formula above in "Expenditures Claimable for FFP", the percent (%) to be applied to Allowable Costs by IHE will be calculated using the percent calculation, shown here and above, and described below.



- A. The percent (%) ("Workforce Participation %") will be determined by matching the:
 1. The Numerator = Graduates of an IHE employed by a Rhode Island Medicaid provider as determined from wage records by person by type of Rhode Island employer by health-related NAICS Code (North American Industry Classification System).

The North American Industry Classification System or **NAICS** (pronounced "nakes") is a numbering system (called "NAICS code") that employs a five or six-digit code at the most detailed industry level. EOHHS will review the NAICS classifications and identify those codes that are relevant to health care providers.

Against,

2. The Denominator = Graduates¹ from each IHE trained in a health profession, as determined by CIP Code (**C**lassification of **I**nstructional **P**rograms).

¹Where "graduate" is an employed individual in Rhode Island who graduated from an "allowable health care training program", as defined by allowable CIP codes.

- B. The Workforce Participation % will be calculated utilizing the most recently available graduation and employment data. The lag time for availability of relevant graduation and employment data is approximately one year after the end of the academic year; for example, 2015 data is available in the Summer of 2016; therefore, as an approximation for the 2017 workforce %, the most recently available actual data (2015 for academic year 2017) will be utilized for application to the 2016-2017 academic year costs. Thereafter, the participation % to be applied to the allowable costs will be based on the most recently available actual academic year data.

Workforce Data Source

Both the graduate level data and the employer data will be obtained by EOHHS from agencies which specialize in tracking of labor and employment statistics and include the Rhode Island Office of the Postsecondary Commissioner, the Rhode Island Department of Labor and Training and the Providence Plan (<http://provplan.org/>).

Claiming

Upon receipt of **Exhibit A** with the attachment **Exhibit B** from each IHE, EOHHS will review the submission and, as necessary, within 10 business days of receipt raise questions with the IHE for resolution within 10 business days. Once the IHE affirms the submitted costs, EOHHS will apply the Workforce percentage defined in "Workforce Calculation Methodology" above and calculate "Total Claimable Expenditures". EOHHS will then follow their existing procedures for claiming the FFP.

Reporting

EOHHS will include claimed DSHP expenditures on the CMS-64 schedule for each quarter. The IHEs quarterly expenditure reports will be a part of the quarterly report to CMS and will include the specific programs with the respective CIP Codes listed on each school's report.

Changes to Previously Claimed Amounts

EOHHS shall inform the IHE of any communication and provide the IHE with a copy of any letter or other communication from state or federal officials or staff relating to questions, audits, review, request for information, deferral, recoupment or disallowance of FFP for expenditures certified by the IHE.

The IHE shall inform EOHHS of any communication and provide EOHHS with a copy of any letter or other communication from state or federal officials or staff relating to questions, audits, review,

request for information, deferral, recoupment or disallowance of FFP for expenditures certified by the IHE pursuant to this Agreement.

Exhibit A: Expenditure Verification (EV) Form

(See next page for form; MS Word version imbedded here for use)



Exhibit A - VE
draft_03.23.17.docx



Designated State Health Program EXPENDITURE VERIFICATION (EV)

The State of Rhode Island and Providence Plantations Medicaid Agency (EOHHS) requires certain information to enable EOHHS to recognize costs incurred for services rendered for Designated State Health Program (DSHP) as allowable expenditures. The Expenditure Verification (EV) form provides EOHHS with verification of expenditures by Rhode Island's public Institutions of Higher Education which will allow EOHHS to draw federal matching funds.

This mandatory form will be retained as part of the fiscal documentation for EOHHS.

The completed and signed EV form must be submitted to the attention of the DSHP Project Director by FAX to (401) 462-4652; by email to paul.loberti@ohhs.ri.gov or mailed to:

Paul G. Loberti, MPH

Administrator for Medical Services & DSHP Project Director

RI EOHHS

Hazard Building

74 West Road

Cranston, RI 02920

SECTION I – IHE INFORMATION

Report Period

Federal Identification Number

Name and Address – IHE

SECTION II - VERIFICATION

This is to verify that:

- I am authorized to review, sign, and submit this form on behalf of this IHE.
- This IHE expended \$ _____ in general funds for eligible Rhode Island Designated State Health Programs (DSHP), as approved by CMS October 20, 2016 in the 11-W-00242/1 amendment to Rhode Island's section 1115 Demonstration Waiver. Attached in Exhibit B, is the Allowable Cost report showing the expenditures identified for the approved DSHP program(s).
- The report period submitted is: _____ (mm-dd-yy), through _____ (mm-dd-yy).
- These expenditures do not include costs used to meet federal maintenance of effort requirements nor to provide match for any other federal purpose or grant and do not exceed the State's annual appropriation.
- Records documenting these expenditures are available for audit by EOHHS.
- I have reviewed the foregoing and verify that the information reported is true and correct to the best of my knowledge and belief.

SECTION III – SIGNATURE

SIGNATURE – Authorized Representative

Date Signed

Name – Authorized Representative (print)

Telephone Number – Authorized Representative

Title – Authorized Representative

Email Address – Authorized Representative

Exhibit B: Allowable Cost Reporting

2. Allowable Cost Reporting Template

(See below for example of form; MS Excel version imbedded here for use)



Exhibit B - IHE
Allowable Cost Repor



Health Workforce Development
Allowable Cost Reporting

| (a) | (b) | (c) | (d) | (e) | (f) | (g) = (f) * % | (h) = (f) * % | (i) = (g) + (h) | (j) = (e) + (i) |
|--------------------|----------------------|-----------------|------------------------------------|-----------------------------------|--|---|---|----------------------|-----------------|
| Line # | CIP Ref ¹ | College | Dept Name ¹ | Total Direct Costs ^{2,3} | Indirect Cost Base (i.e., salary and/or fringe cost component of .(e)) | Indirect Costs On Campus ⁴ (%) | Indirect Costs Off Campus ⁴ (%) | Total Indirect Costs | Total Costs |
| | | | | | | 0% | 0% | | |
| 1 | | Health Sciences | Psych/CPRC | | | 0.00 | 0.00 | - | - |
| 2 | | Health Sciences | Psychology | | | 0.00 | 0.00 | - | - |
| 3 | | Health Sciences | Human Dev/Fam Studies | | | 0.00 | 0.00 | - | - |
| 4 | | Health Sciences | Communicative Disorders | | | 0.00 | 0.00 | - | - |
| 5 | | Health Sciences | Physical Therapy | | | 0.00 | 0.00 | - | - |
| 6 | | Health Sciences | Gerontology | | | 0.00 | 0.00 | - | - |
| 7 | | Health Sciences | Kinesiology | | | 0.00 | 0.00 | - | - |
| 8 | | Health Sciences | King, Child Development | | | 0.00 | 0.00 | - | - |
| 9 | | Health Sciences | Health Studies | | | 0.00 | 0.00 | - | - |
| 10 | | Health Sciences | Nutrition | | | 0.00 | 0.00 | - | - |
| 11 | | CEPS | Medical Lab Science | | | 0.00 | 0.00 | - | - |
| 12 | | Nursing | Nursing Admin | | | 0.00 | 0.00 | - | - |
| 13 | | Nursing | Nursing Instruction | | | 0.00 | 0.00 | - | - |
| 14 | | Pharmacy | Pharmacy Dean | | | 0.00 | 0.00 | - | - |
| 15 | | Pharmacy | Pharmacy Practice | | | 0.00 | 0.00 | - | - |
| 16 | | Pharmacy | Biomedical and Pharmaceut. Science | | | 0.00 | 0.00 | - | - |
| Grand Total | | | | - | - | - | - | - | - |
| | | | | | | BOX A | Work Force Employment in RI⁵ | | |
| | | | | | | BOX B | Total Graduates⁵ | | |
| | | | | | | BOX C | Work Force Participation % in RI⁵ | | % |
| | | | | | | BOX D | Total Allowable Costs | | \$ |

Footnotes

¹ Department/Program must be matched with one or more CIP codes

² \$'s reported in accordance with guidance of Superdircular and NACUBO Principles

³ Funding sources as defined

⁴ Federally approved indirect rates

⁵ Data provided by RI Office of the Post-Secondary Commissioner, the Rhode Island Department of Labor and Training and the Providence Plan

3. Instructions for Completing Allowable Cost Reporting Template

| Column Ref | Instructions | Responsibility |
|------------|--|----------------|
| Column A | This column identifies the line number of the data and is used for reference purposes only. The IHE should add or delete lines as appropriate to the number of Departments listed in Column D. | IHE |
| Column B | Insert the CIP code in this column that identifies the program of instruction in Column D as classified under the National Center for Education Statistics Classification of Instructional Programs. | IHE |
| Column C | Insert the name of the Department or College the Allowable educational Program in Column D is offered under. | IHE |
| Column D | Insert the name of the Allowable educational Program agreed to with EOHHS | IHE |
| Column E | Insert the total Allowable Costs for the respective Allowable Program. | IHE |
| Column F | Insert the total Allowable Costs to which the indirect rate is applicable for the respective Allowable Program. | IHE |
| Column G | Insert the federally approved On-Campus indirect rate in Cell G6. The remainder of Column G will automatically calculate. | IHE |
| Column H | Insert the federally approved Off-Campus indirect rate in Cell H6. The remainder of Column H will automatically calculate. | IHE |
| Column I | Column I will automatically populate and total Columns G and H and represents the total of Indirect Costs by Allowable Program. | Calculated |
| Column J | Column J will automatically populate and total Columns E and I and represents the Total Allowable Costs by Allowable Program. | Calculated |

EOHHS will then apply the % of Workforce Participation of Program Graduates by IHE to total Allowable Costs for that IHE as follows (*see “Workforce Calculation Methodology” herein for reference*):

| | |
|-------|---|
| Box A | Populate the number of graduates that obtained relevant employment in Rhode Island with data provided by the external reporting agencies. |
| Box B | Populate the number of graduates from the IHE with data provided by the external reporting agencies. |
| Box C | Automatically calculates by dividing Box A by Box B to yield the Workforce Participation %. |
| Box D | Automatically calculates multiplying total Allowable Costs by Box C the Workforce Participation % and represents the total amount of Allowable Costs that EOHHS will claim for FFP match. |

Attachment T: Deliverables Chart – 5 Years

| DY | Quality/Operational Improvement Targets | Due Date | % Reduction if State does not meet |
|----------------|---|-------------------|------------------------------------|
| DY 8 CY 16 | <i>To ensure prompt responses to CMS' questions regarding managed care rate development, CMS is adding the following items to the state's deliverable list. EOHHS will respond to CMS questions provided in writing to the state, regarding their managed care capitation rate development within 4 weeks of the request by CMS. If EOHHS anticipates that responses will not be available within the timeframe, EOHHS must notify CMS in writing, within 1 week of receipt of CMS request and request a reasonable extension, taking into account the content and volume of questions.</i> | | |
| | EOHHS Responds to all CMS questions, received prior to 10/14/2016 regarding the 2015 managed care rate certification submissions. | Dec 1, 2016 | 15% |
| | EOHHS Submits to CMS their 2016 managed care rate certification | Dec 1, 2016 | 15% |
| DY 9 CY 17 | EOHHS Submits the AE Roadmap document to CMS, including AE-Specific Health Transformation Project | June 1, 2017 | 10% |
| | EOHHS Submits their DSHP Claiming Protocols; Attachment P, Attachment Q, Attachment R and Attachment S | May 15, 2017 | 15% |
| | EOHHS Submits AE Certification Standards to CMS | June 1, 2017 | 10% |
| | EOHHS Submits Attribution Guidance to CMS | October 1, 2017 | 5% |
| | EOHHS Submits APM program guidelines to CMS, includes TCOC methodology and benchmarks | October 1, 2017 | 10% |
| DY 10 CY 18 | Each MCO has at least 2 effective contracts (or 10% of covered lives) with Certified AEs in an EOHHS approved Alternative Payment Model as defined in Attachment L. | November 1, 2018 | 15% |
| | EOHHS Year 2 Guidance Posted, includes: APM Program Guidance, Attribution Guidance, and AE Incentive Program Guidance | December 15, 2018 | 5% |
| DY 11 CY 19 | Each MCO has at least 2 effective contracts (or 20% of covered lives) with Certified AEs in an EOHHS approved Alternative Payment Model as defined in Attachment L. 10% of covered lives shall be through an EOHHS Approved Alternative Payment Methodology that includes shared or full risk. | July 1, 2019 | 10% |
| | EOHHS Year 3 Guidance Posted, includes: APM Program Guidance, Attribution Guidance, and AE Incentive Program Guidance | December 15, 2019 | 5% |

| | | | |
|----------------|---|-------------------|-----|
| | Applicable AEs have demonstrated achievement of pre-determined performance benchmarks for established measures in the APM guidance document – Attachment L, for measurement period of July 1, 2018 through June 30, 2019. | December 31, 2019 | 5% |
| DY 12 CY 20 | Each MCO has at least 3 effective contracts (or 30% of covered lives) with Certified AEs in an EOHHS approved Alternative Payment Model as defined in Attachment L. 20% of covered lives shall be through an EOHHS Approved Alternative Payment Methodology that includes shared or full risk. | July 1, 2020 | 10% |
| | EOHHS Year 3 Guidance Posted, includes: APM Program Guidance, Attribution Guidance, and AE Incentive Program Guidance | December 15, 2020 | 5% |
| | Applicable AEs have demonstrated achievement of pre-determined performance benchmarks for established measures in the APM guidance document – Attachment L, for measurement period of July 1, 2019 through June 30, 2020. | December 31, 2020 | 5% |