CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00242/1**

TITLE: **Rhode Island Global Consumer Choice Compact Section 1115 Demonstration**

AWARDEE: **Rhode Island Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Rhode Island Global Consumer Choice Compact section 1115(a) Medicaid demonstration ("Demonstration"), as approved under authority of section 1115 of the Social Security Act, (the Act). The parties to this agreement are the Rhode Island Department of Human Services (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 STCs are effective December 1, 2009, 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 All previously approved section 1115(a) demonstration STCs, waivers, and expenditure authorities are superseded by the STCs set forth below and accompanying waivers and expenditure authorities. This Demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Program Flexibility - Administrative Processes 1, 2, and 3
V. Eligibility, Benefits, and Enrollment
VI. Cost Sharing
VII. Delivery Systems: Assessment and Coordination Organization, Fee-for-Service, Self-Direction, Managed Care Organization, Primary Care Case Management Program, Pre-paid Ambulatory Health Plans
VIII. Self-Direction
IX. Extended Family Planning
X. RIte Smiles
XI. Healthy Choice Accounts
XII. General Reporting Requirements
XIII. General Financial Requirements
XIV. Monitoring Budget Neutrality
XV. Quality Assurance and Improvement
XVI. Evaluation of the Demonstration

XVII. Schedule of Deliverables

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: Services
Attachment B: HCBS Core Service Definitions
Attachment C: Family Planning
Attachment D: Assessment and Coordination Organization Description and Level of Care Criteria
Attachment E: Level of Care
Attachment F: Quarterly Report
Attachment G: Interim Procedural Guidance for Conducting Quality Reviews of HCBS Waiver Programs: *Attachment D HCBS Quality Review Worksheet*

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 Global Consumer Choice Compact 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. In exchange for the increased flexibility and the opportunity to invest in Medicaid reform, the State will operate the Medicaid program during the Demonstration under a mutually agreed upon 5-year aggregate cap of Federal funds, thereby assuming a degree of financial risk with respect to caseload and per-member per-month cost trends.

Accordingly, Rhode Island will operate 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, will be subject to the financial requirements of the Demonstration. Rhode Island's section 1115 RIte Care and RIte Share demonstrations for children and families and the section 1915(b) Dental Waiver will be terminated and the subject

populations and services are included as demonstration populations and services under the authority of this demonstration. Rhode Island's section 1915(c) home and community-based services (HCBS) waivers will also be terminated, and Rhode Island will include the subject populations and services under this demonstration.

The Special Terms and Conditions set forth herein define the scope of the Demonstration and serve as the compact between the Federal Government and the State governing operations of the Medicaid program with respect to:

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

Aggregate Budget Ceiling: Federal financial responsibilities will be subject to an aggregate budget ceiling. While the State will be at risk for caseload and unforeseen cost trends, it will have tools under the demonstration to adjust demonstration operations so that the State's financial responsibilities are within its budget targets. These tools include:

- Savings Reinvestment: The authority of the State to utilize savings achieved in conjunction with implementation of the Demonstration to promote the following core principles of reform:

- Consumer Empowerment and Choice: To provide consumers more information and control over their health care and community support options.

- Personal Responsibility: To allow consumers to become better health care purchasers for themselves and their families.

- Community-based care solutions: To offer community-based health care solutions and alternatives to institutional care for individuals who can appropriately remain in their communities.

- Prevention and Wellness: To strive to better enable consumers to receive individualized health care that is outcome-oriented and focused on prevention, wellness, recovery, and maintaining independence.

- Competition and Value: To allow for greater competition between health care providers and ensure cost-effective purchasing strategies that promote value to taxpayers.

- Pay for Performance: To employ Medicaid purchasing and payment methods that encourage and reward service quality and cost-effectiveness by linking

reimbursements to common, evidence-based quality performance measures, including patient satisfaction.

III. GENERAL PROGRAM REQUIREMENTS

1. **Concurrent Operation:** The State's title XIX State plan as approved; its title XXI State plan, as approved; and its Medicaid section 1115 demonstration entitled "Rhode Island Global Consumer Choice Compact," for the demonstration period will continue to operate concurrently.

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 State 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 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 17 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.

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 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 Cap: 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.

8. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein should be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated, FFP must be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

9. **Enrollment Limitation During Demonstration Phase-Out**. If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 8, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled. Enrollment must also be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

10. **CMS Right to Terminate or Suspend for Cause.** CMS may 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 17 of Section IV, Program Flexibility.

15. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval 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 17, "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.

16. **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 calendar 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 70 through 72. 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 section1915(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, 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, 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/MR, hospital, or nursing home level of care criteria that are applied prospectively (not to existing long term care or HCBS recipients);
- Adding any HCBS service for which the State intends to use a definition other than the core definition; the service definition must be included with the assurances;
- Modifying any HCBS service definition, unless it is to adopt the core definition;
- Adding an "other" HCBS service that does not have a core definition; the service definition must be included with the assurances;
- Removing any HCBS service that is at that time being used by any participants;
- Change/modify or end RIte Share premium assistance options for otherwise eligible individuals;
- Changes to payment methodologies for Medicaid covered services including, but not limited to, DRG payments to hospitals or acuity based payments to nursing homes;
- Healthy Choice Accounts Initiatives;
- Addition or elimination of optional State plan benefits;
- Changes in the amount, duration, and scope of State plan benefits that do not affect the overall sufficiency of the benefit;
- Benefit changes in accordance with the DRA Benchmark flexibility; and

- Cost-Sharing Changes up to the DRA limits unless otherwise defined in the STCs or currently waived.

c) **Category III Change**: Is a change requiring modifications to the current waiver or expenditure authorities including descriptive language within those authorities and the STCs, and any other change that is not clearly described within Categories I and II. In addition, a programmatic change may be categorized as a Category III change by the State to obtain reconsideration after unsuccessfully pursuing approval of the change under Category II. The State must comply with 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 17, "Process for Changes to the Demonstration." Category III changes shall not be implemented until after approval of the amendment by CMS.

Examples of Category III changes:

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

17. **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 calendar days of any correction to the State's characterization of a change, which shall be binding and non-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.

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.

a) 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.

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 17 (c) (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 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) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

V. ELIGIBILITY, BENEFITS, AND ENROLLMENT

18. **Overview.** The Global Consumer Choice Compact includes the following distinct components:

a) The RIte Care component provides Medicaid State Plan benefits and others as identified in Attachment A to most recipients eligible under the Medicaid State plan who are not enrolled in Rhody Health Partners or Connect Care Choice. 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 FPL, and who lose Medicaid eligibility under RIte Care at the conclusion of their 60-day postpartum period. See Section IX for more detailed requirements.

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) The Rhody Health Partners component provides Medicaid State Plan benefits through a managed care delivery system to aged, blind, and disabled beneficiaries who have no other health insurance. 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.

19. **Specific Eligibility Criteria.** Mandatory and optional Medicaid and/or CHIP State Plan groups described below 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 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.

    Below is a chart that provides an overview of the eligibility groups. Eligibility will be determined by the Rhode Island Medicaid State Plan, the Rhode Island CHIP State Plan, or the definition(s) of demonstration eligible expansion populations.

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

Categorically Needy Medicaid Eligibility Groups

Mandatory Categorically Needy Coverage Groups

Medicaid Eligibility Groups	***Income and Resource Standards and/or Other Qualifying Criteria***	***Expenditure and CMS 64 Eligibility Group Reporting***
§1931 low income families with children §1902(a)(10)(A)(i)(I); §1931	*Income*: Up to 110% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Children receiving IV-E payments (IV-E foster care or adoption assistance) §1902(a)(10)(A)(i)(I)	*Income*: Up to 100% of FPL *Resource*: No resource test	Budget Population 4 CSHCN

Individuals who lose eligibility under §1931 due to employment §1902(a)(10)(A)(i)(I); §402(a)(37); §1925	*Income*: Up to 110% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Individuals who lose eligibility under §1931 because of child or spousal support §1902(a)(10)(A)(i)(I); §406(h)	*Income*: Up to 110% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Individuals participating in a work supplementation program who would otherwise be eligible under §1931 §1902(a)(10(A)(i)(I); §482(e)(6)	*Income*: Up to 110% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Individuals who would be eligible AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972) 42 CFR 435.114	*Income*: Up to 110% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Disabled children no longer eligible for SSI benefits because of a change in definition of disability §1902(a)(10)(A)(i)(II)(aa)	*Income*: 100% SSI *Resource*: $2,000	Budget Population 1 ABD no TPL
Individuals under age 21 eligible for Medicaid in the month they apply for SSI §1902(a)(10)(A)(i)(II)(cc)	*Income*: 100% SSI *Resource*: $2,000	Budget Population 1 ABD no TPL
Qualified pregnant women §1902(a)(10)(A)(i)(III); §1905(n)(1)	*Income*: Up to 100% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Qualified children §1902(a)(10)(A)(i)(III); §1905(n)(2)	*Income*: Up to 100% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Poverty level pregnant women and infants §1902(a)(10)(A)(i)(IV)	*Income*: Up to 185% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Qualified family members §1902(a)(10)(A)(i)(V)	*Income*: Up to 100% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Poverty level children under age 6 §1902(a)(10)(A)(i)(VI)	*Income*: Up to 133% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Poverty level children under age 19, born after September 30, 1983 (or, at State option, after any earlier date) §1902(a)(10)(A)(i)(VII)	*Income*: Up to 100% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Newborns deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant §1902(e)(4)	*Income*: Up to 185% of FPL *Resource*: No resource test	Budget Population 3 RIte Care

Pregnant women who lose eligibility receive 60 days coverage for pregnancy related and post partum services §1902(e)(5)	*Income*: Up to 185% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Pregnant women who lose eligibility because of a change in income remain eligible 60 days post partum §1902(e)(6)	*Income*: Up to 185% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Poverty level infants and children who while receiving services lose eligibility because of age must be covered through an inpatient stay §1902(e)(7)	*Resource*: No resource test	Budget Population 3 RIte Care
Individuals receiving SSI cash benefits §1902(a)(10)(A)(i)(II)	*Income*: 100% SSI *Resource*: $2,000 individual $3,000 couple	Budget Population 1 ABD no TPL
Disabled individuals whose earnings exceed SSI substantial gainful activity level §1619(a)	*Income*: 100% SSI *Resource*: $2,000 individual $3,000 couple	Budget Population 1 ABD no TPL
Disabled individuals whose earnings are too high to receive SSI cash benefits §1902(a)(10)(A)(i)(II)(bb); §1905(q); 1619(b)	*Income*: 100% SSI *Resource*: $2,000 individual $3,000 couple	Budget Population 1 ABD no TPL
Pickle: individuals who would be eligible for SSI if Title II COLAs were deducted from income §503 of P.L. 94-566; §1939(a)(5)(E)	*Income*: 100% SSI *Resource*: $2,000 individual $3,000 couple	Budget Population 1 ABD no TPL
Disabled widows and widowers §1634(b); §1939(a)(2)(C)	*Income*: 100% SSI *Resource*: $2,000 individual	Budget Population 1 ABD no TPL
Disabled adult children who lose SSI due to OASDI §1634(c); §1939(a)(2)(D)	*Income*: 100% SSI *Resource*: $2,000 individual $3,000 couple	Budget Population 1 ABD no TPL
Early widows/widowers §1634(d); §1939(a)(2)(E)	*Income*: 100% SSI *Resource*: $2,000 individual	Budget Population 1 ABD no TPL
Individuals ineligible for SSI/SSP because of requirements prohibited under Medicaid 42 CFR 435.122	*Income*: 100% SSI *Resource*: $2,000 individual $3,000 couple	Budget Population 1 ABD no TPL
Qualified Medicare Beneficiaries §1902(a)(10)(E)(i); §1905(p)(1)	*Income*: 100% of FPL *Resource*: $4,000 single $6,000 couple	Budget Population 2 ABD TPL

Qualified disabled and working individuals (defined in §1905(s)); not otherwise eligible for Medicaid §1902(a)(10)(E)(ii)	*Income*: 200% of FPL *Resource*: $4,000 single $6,000 couple	Budget Population 2 ABD TPL
Specified Low-Income Medicare Beneficiaries §1902(a)(10)(E)(iii)	*Income*: >100% but =<120% of FPL *Resource*: $4,000 single $6,000 couple	Budget Population 2 ABD TPL
Qualified Individuals; not otherwise eligible for Medicaid §1902(a)(10)(E)(iv)	*Income*: >120 percent but =<135 percent of FPL *Resource*: $4,000 single $6,000 couple	Budget Population 2 ABD TPL

Optional Categorically Needy Coverage Groups

Medicaid Eligibility Groups	***Income and Resource Standards and/or Other Qualifying Criteria***	***Expenditure and CMS 64 Eligibility Group Reporting***
Individuals who are eligible for, but not receiving IV-A §1902(a)(10)(A)(ii)(I)	*Income*: Up to 110% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Individuals who are eligible for IV-A cash assistance if State did not subsidize child care §1902(a)(10)(A)(ii)(II)	*Income*: Up to 110% of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Children under age 1	*Income:* Up to 250% of FPL *Resource:* No resource test	Budget Population 3 RIte Care
Children under 21, (or at State option, 20, 19, or 18) who are under State adoption agreements §1902(a)(10)(A)(ii)(VIII)	*Income*: Title IV-E (§1931 Standard; Up to 110% of FPL) *Resource*: Title IV-E (§1931 Standard; no resource test)	Budget Population 4 CSHCN
Independent foster care adolescents §1902(a)(10)(A)(ii)(XVII)	*Income*: 110% of FPL *Resource*: No resource test	Budget Population 4 CSHCN
Optional Targeted Low Income Children §1902(a)(10)(A)(ii)(XIV); §1905(u)(2)	*Income*: =< 250% *Resource*: No resource test	Budget Population 7 XXI Children
Individuals under 21 or at State option, 20, 19, 18, or reasonable classification [1] §1905(a)(i); 42 CFR 435.222	*Income*: Up to 110% of FPL *Resource*: No resource test	Budget Population 4 CSHCN

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

Individuals who are eligible for, but not receiving, SSI or State supplement cash assistance §1902(a)(10)(A)(ii)(I)	*Income*: 100% SSI *Resource*: $2,000 individual $3,000 couple	Budget Population 1 ABD no TPL
Individuals who would have been eligible for SSI or State supplement if not in a medical institution §1902(a)(10)(A)(ii)(IV)	*Income*: 100% SSI *Resource*: $2,000 individual $3,000 couple	Budget Population 1 ABD no TPL
Special income level group: individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of SSI income standard §1902(a)(10)(A)(ii)(V)	*Income*: 300% of SSI Federal benefit level *Resource*: $2,000 individual $3,000 couple	Budget Population 1 ABD no TPL
Aged or disabled individuals whose SSI income does not exceed 100% of FPL §1902(a)(10)(A)(ii)(X)	*Income*: =< 100% FPL *Resource*: $4,000 individual $6,000 couple	Budget Population 1 ABD no TPL
Individuals receiving only an optional State supplement payment which may be more restrictive than the criteria for an optional State supplement under title XVI §1902(a)(10)(A)(ii)(XI)	*Income*: based on living arrangement cannot exceed 300% SSI *Resource*: $2,000 individual $3,000 couple	Budget Population 1 ABD no TPL
BBA working disabled group: Working disabled individuals who buy in to Medicaid §1902(a)(10)(A)(ii)(XIII)	*Income*: Up to 250% FPL *Resource*: Up to $10,000 individual Up to $20,000 couple	Budget Population 1 ABD no TPL
Uninsured women, under 65, who are screened for breast or cervical cancer under CDC program and not eligible for Medicaid §1902(a)(10)(A)(ii)(XVIII)		Budget Population 14 BCCTP
TEFRA section 134 children: disabled individuals age 18 or under who require an institutional level of care; care can be provided outside the institution; estimated amount for home care can be no more than estimated amount for institutional care §1902(e)(3)	*Income*: 300% of SSI Federal benefit level *Resource*: $2,000	Budget Population 4 CSHCN
Presumptive eligibility for women who are screened for breast or cervical cancer under CDC program §1920B		Budget Population 14 BCCTP

Medically Needy Medicaid Eligibility Groups

Mandatory Medically Needy Coverage Groups

Medicaid Eligibility Groups	*Income and Resource Standards and/or Other Qualifying Criteria*	*Expenditure and CMS 64 Eligibility Group Reporting*
Individuals under 18 who would be mandatorily categorically eligible except for income and resources §1902(a)(10)(C)(ii)(I)	*Income*: 133 1/3 % of §1931 income standard *Resource*: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100	Budget Population 3 RIte Care
Pregnant women who would be categorically eligible except for income and resources §1902(a)(10)(C)(ii)(II)	*Income*: 133 1/3 % of §1931 income standard *Resource*: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100	Budget Population 3 RIte Care
Newborns, who except for income and resources would be eligible as categorically needy, deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant §1902(a)(10)(C); §1902(e)(4)	*Income*: 133 1/3 % of §1931 income standard *Resource*: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100	Budget Population 3 RIte Care
Pregnant women who lose eligibility received 60 days coverage for pregnancy-related and post partum services §1902(a)(10)(C); §1902(e)(5)	*Income*: 133 1/3 % of §1931 income standard *Resource*: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100	Budget Population 3 RIte Care
All individuals under 21 or at State option, 20, 19, or 18 or reasonable classifications who would not be covered under mandatory medically needy group of individuals under 18 §1902(a)(10)(C); §1905(a)(i)[2]	*Income*: 133 1/3 % of §1931 income standard *Resource*: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100	Budget Population 3 RIte Care

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

Specified relatives of dependent children who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(ii)	*Income*: 133 1/3 % of §1931 income standard *Resource*: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100	Budget Population 3 RIte Care

Optional Medically Needy Coverage Groups

Medicaid Eligibility Groups	***Income and Resource Standards and/or Other Qualifying Criteria***	***Expenditure and CMS 64 Eligibility Group Reporting***
Aged individuals who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(iii)	*Income*: 133 1/3 % of §1931 income standard *Resource*: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100	Budget Population 1 ABD no TPL
Blind individuals who are ineligible as categorically needy §1902(a)(10)(C);§1905(a)(iv)	*Income*: 133 1/3 % of §1931 income standard *Resource*: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100	Budget Population 1 ABD no TPL
Disabled individuals who are ineligible as categorically needy §1902(a)(10)(C); §1902(v)	*Income*: 133 1/3 % of §1931 income standard *Resource*: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100	Budget Population 1 ABD no TPL
TEFRA section 134 children: disabled individuals age 18 or under who require an institutional level of care; care can be provided outside the institution; estimated amount for home care can be no more than estimated amount for institutional care §1902(e)(3)	*Income*: 300 % of SSI Federal benefit level *Resource*: $4,000	Budget Population 4 CSHCN

ELIGIBILITY GROUPS UNDER THE DEMONSTRATION

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

Medicaid Eligibility Groups	***Income and Resource Standards and/or Other Qualifying Criteria***	***Expenditure and CMS 64 Eligibility Group Reporting***
Parents/Caretakers with Children	*Income*: Above 110% to 175% FPL *Resource*: No resource test	Budget Population 3 RIte Care
Pregnant Women without third party liability or other coverage in the event that title XXI funds are exhausted	*Income*: Above 185% to 250% FPL *Resource*: No resource test	Budget Population 6a RIte Care
Pregnant Women with third party liability or other coverage	*Income*: Above 185% to 250% FPL *Resource*: No resource test	Budget Population 6b RIte Care
Children Under 6	*Income*: Above 133% to 250% FPL *Resource*: No resource test	Budget Population 3 RIte Care
Children Under 19	*Income*: Above 100% to 250% FPL *Resource*: No resource test	Budget Population 3 RIte Care

Expansion Groups Under §1115 Demonstration

Medicaid Eligibility Groups	***Income and Resource Standards and/or Other Qualifying Criteria***	***Expenditure and CMS 64 Eligibility Group Reporting***
Women who lose Medicaid eligibility 60 days postpartum received 24 months of family planning services	*Income*: Up to 200% FPL *Resource*: No resource test	Budget Population 5 EFP
Children and families in managed care enrolled in RIte Care (children under 19 & parents) when the parents have behavioral health conditions (substance abuse/mental illness) that result in their children being placed in temporary State custody.	Income: Up to 200% FPL Resource: No resource test	Budget Population 8 Substitute Care
Children with special health care needs (as an eligibility factor) who are 21 and under who would otherwise be placed in voluntary state custody—residential diversion	Income: 300 % of SSI Resource: No resource test	Budget Population 9 CSHCN not voluntarily placed in State custody

Individuals 65 and over at risk for LTC who are in need of home and community-based services (State only group).	Income: At or below 200% of the FPL Resource: No resource test	Budget Population 10 Elders at risk for LTC
Categorically Needy Individuals under the State plan receiving HCBW services & PACE-like participants highest need group	Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under 42 CFR 435.217, 435.726 and 435.236 and section 1924 of the Social Security Act, if the State had 1915(c) waiver programs.	Budget Population 11 217 & PACE-like Categorically needy Highest
Categorically needy individuals under the State plan receiving HCBW services & PACE-like participants high need group	Use institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner as specified under 42 CFR 435.217, 435.236, and 435.726 of the Federal regulations and section 1924 of the Social Security Act, if the State had 1915(c) waiver programs.	Budget Population 12 217 & PACE-like Categorically needy High
Medically needy under the State Plan receiving HCBW services in the community (high and highest group) Medically needy PACE-like participants in the community	Apply the medically needy income standard plus $400 and use institutional eligibility rules, including the application of spousal impoverishment eligibility rules.	Budget Population 13 217 & PACE-like Medically needy High & Highest
Adults with disabilities served by the Office of Rehabilitation Services (ORS) who are not eligible for Medicaid, but may become eligible if these services are not provided	Income: Up to 300% of SSI	Budget Population 15 Adults with disabilities at risk for long-term care.
Services for uninsured adults w/mental illness and/or substance abuse problems who are at risk for a hospital level of care	Income: Up to 200% of the FPL	Budget Population 16 Uninsured adults with mental illness
Medicaid eligible youth who are at risk for placement in residential treatment facilities and or inpatient hospitalization	Income: Up to 250% FPL Resource	Budget Services 4 At risk youth Medicaid eligible

Children under age 18 who are at risk for Medicaid or institutional care not eligible for Medicaid	Income: Up to 300% of SSI for child Resource:	Budget Population 17 Youth at risk for Medicaid
HIV Positive individuals who are otherwise ineligible for Medicaid	Incomes: At or below 200% of the FPL	Budget Population 18 HIV
Adults – ages 19-64 – who are unable to work due to a variety of health conditions, but do not qualify for disability benefits.	Income: Up to 200% FPL Resource:	Budget Population 19 Non-working disabled adults

20. **AFDC-Related Eligibility Determinations.** 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, 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.

21. **Resource Test**: 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.

22. **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.

23. **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.

24. **Individuals Receiving section 1915(c)-Like Services.**
    i) **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.

ii) **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.

iii) **Medically Needy at the High and Highest Level of Care.** The State will apply the medically needy income standard plus $400 and otherwise use institutional eligibility rules, including the application of spousal impoverishment eligibility rules.

iv) **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.

25. **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 17 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.

26. **Benefits.** Benefits provided through this demonstration program are as follows:

a) **RIte Care.** Benefits are the full scope of benefits set forth in the approved State plan as of November 1, 2008, unless specified in this document. Benefits are delivered through managed care organizations or managed care delivery systems, with the exception of certain services paid by the State on a fee-for-service basis. Benefits that are available to RIte Care enrollees under this Demonstration include all benefits listed in Attachment A. 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.

b) **Extended Family Planning Program.** Family planning services and referrals to primary care services are provided for a maximum period of 24 months to eligible recipients at or

below 200 percent of the FPL who lose Medicaid eligibility at the conclusion of their 60-day postpartum period. See Section IX for more detailed requirements.

c) **Long-Term Care and HCBS**. Long term care services are provided when medically necessary to all individuals eligible under the Medicaid State plan. Benefit packages include long-term care and home and community-based services based on medical necessity and an individual's plan of care. 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 27, subject to any waiting list as described in paragraph 28. The core and preventive service HCBS definitions are included in Attachment B of this document. More detailed requirements are provided in this section in paragraphs 27-29.

27. **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, in the absence of other comprehensive health insurance. 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 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.

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

29. **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 or 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.

30. **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.

31. **Long-Term Care Insurance Partnership.** The State may 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.

VI. COST SHARING

32. The following premium and co-payment limits apply to the populations as noted below.

	Budget Populations 3, 6, and 8									
	children under 1*		children 1 to 19th birthday*		adults		pregnant women		extended family planning	
Family Income	premiums	copays	premium	copays	premium	copays	premium	copays	premium	copays
Under 100% FPL	none	None	none	None	none	None	none	None	none	$2 health care provider visits $1 for 30 day supply of contraceptives $15 voluntary sterilization procedures
100-133% FPL	none	None	none	None	none	None	none	None	none	$2 health care provider visits $1 for 30 day supply of contraceptives $15 voluntary sterilization procedures
133-150% FPL	none	$5 generic Rx $10 brand Rx $25 non-emergency use of ER	up to 5% of family income	$5 generic Rx $10 brand Rx $25 non-emergency use of ER	up to 5% of family income	$5 generic Rx $10 brand Rx $25 non-emergency use of ER	none	$5 generic Rx $10 brand Rx $25 non-emergency use of ER	none	$2 health care provider visits $1 for 30 day supply of contraceptives $15 voluntary sterilization procedures
150-185% FPL (150-175% FPL for adults)	none	$5 generic Rx $10 brand Rx $25 non-emergency use of ER	up to 5% of family income	$5 generic Rx $10 brand Rx $25 non-emergency use of ER	up to 5% of family income	$5 generic Rx $10 brand Rx $25 non-emergency use of ER	none	$5 generic Rx $10 brand Rx $25 non-emergency use of ER	none	$2 health care provider visits $1 for 30 day supply of contraceptives $15 voluntary sterilization procedures

185-250% FPL	up to 5% of family income	$5 generic Rx $10 brand Rx $25 non-emergency use of ER	up to 5% of family income	$5 generic Rx $10 brand Rx $25 non-emergency use of ER	n/a	n/a	up to 5% of family income	$5 generic Rx $10 brand Rx $25 non-emergency use of ER	none	$2 health care provider visits $1 for 30 day supply of contraceptives $15 voluntary sterilization procedures
*no cost sharing or premiums for children in foster care or adoption subsidy					No cost-sharing for Chafee children					

- 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.

VII. DELIVERY SYSTEM

33. **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 D.

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

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

    Self-direction: Beneficiaries and their families will also have the option to purchase HCBS waiver like services through a self-direction service delivery system. Under this option, beneficiaries will work with the ACO to develop a budget amount for services needed. The beneficiary, with the support of a fiscal intermediary, will then be able to purchase services directly. This option is based on experience from Rhode Island's 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.

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

    Managed Care Organizations: *RIte Care, RIte Share Rhody Health Partners, and PACE*
    Primary Care Case Management Program: *Connect Care Choice*
    Pre-paid Dental Ambulatory Health Plans: *RIte Smiles*
    Fee-for-service

36. **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).

    The State will continue to maintain a contract with a health care management consulting firm experienced in health plan management, which will be responsible for managing the operational and administrative aspects of the program under the State's direction.

37. **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 global demonstration.

38. **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 that are consistent with the requirements of 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 the requirements of section 1923 of the Act, and 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.

39. **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.

VIII. SELF-DIRECTION

40. **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 for children in residential treatment who are transitioning back to a home-based setting.

41. **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.

42. **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.

43. **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.

44. **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.

45. **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.

46. **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.

47. **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.

48. **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. Modifications to the budget must be preceded by a change in the service plan.

49. **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.

50. **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.

51. **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.

52. **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.

53. **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.

54. **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.

55. **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.

56. **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.

57. **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.

58. **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.

59. **Fair Hearing.** A 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.

60. **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.

61. **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.

IX. EXTENDED FAMILY PLANNING PROGRAM

62. **Extended Family Planning Program.** Family planning services are provided to uninsured women who lose Medicaid eligibility at 60 days postpartum with family income at or below 200 percent of the FPL for a maximum period of 24 months. During the extension period, a new participant will only be considered eligible if her income is no higher than 200 percent of the FPL. The State will have 12 months from the beginning of the extension period to disenroll current enrollees whose income exceeds 200 percent of the FPL at its annual eligibility redetermination.

    a) **Duplicate Payments.** The State must not use title XIX funds to pay for individuals enrolled in Medicare, Medicaid, CHIP, any other Federally funded program (i.e., title X), or component of this section 1115 Demonstration who seek services under the extended family planning program. The State shall only enroll or reenroll an individual into the extended family planning program who is uninsured (defined as not having creditable coverage) and has an income up to and including 200 percent of the FPL. During this 1-year period, the State shall pursue third party liability

reimbursement for any currently enrolled individual who has other insurance and ensure that Medicaid will be the payer of last resort.

b) **Primary Care Referral.** The State shall facilitate access to primary care services for enrollees in the extended family planning program. In addition, the State must evaluate the impact of providing referrals for primary care services. This component of the evaluation must be highlighted in the evaluation design that will be submitted to CMS as specified in section XVI, paragraph 94(b). The State has met the requirement of paragraph 94(b)(d)(9).

c) **Eligibility Redeterminations.** The State will ensure that redeterminations of eligibility for this component of the Demonstration are conducted, at a minimum, once every 12 months.

i. **Process.** The process for eligibility redeterminations shall not be passive in nature, but will require that an action be taken by the extended family planning program recipient in order to continue eligibility for this program. The State may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.

ii. **Integrity.** The State provided to CMS, an appropriate methodology for ensuring the integrity of annual eligibility determinations of individuals covered under the extended family planning program. The State will use this methodology to conduct reviews of the eligibility determination process on an annual basis. As part of the submission, the State will also develop an eligibility determination error rate methodology. If annual reviews of the eligibility determination process suggest error rates beyond a State established threshold, the State will develop a corrective action plan for CMS approval.

iii. **Extended Family Planning Program Income Limit.** Effective October 1, 2008, a new participant will only be considered eligible if her income is no higher than 200 percent of the FPL. The State will have 12 months from the beginning of the extension period to disenroll current enrollees whose income exceeds 200 percent of the FPL at its annual eligibility redetermination. The State shall only enroll or reenroll an individual into the extended family planning program who is uninsured (defined as not having creditable coverage) and who has an income up to and including 200 percent of the FPL.

X. RITE SMILES

63. **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. HEALTH CHOICE ACCOUNTS

64. **Health Choice Accounts**. Within 2 years of implementing the demonstration, the State must submit a proposal to implement a Health Choice Accounts initiative as a Category II change. The Health Choice Account will provide incentives and rewards for healthy behaviors. The Health Choice Account program will allow selected beneficiaries to receive a periodic report that itemizes the type of services available, the costs for each service, as well as the amount of State contribution available to the individual. The State may set limits on the amount, scope and duration of services, including establishing an individualized budget, for optional populations that the State deems appropriate for its Health Choice Account program. Each family member with a Health Choice Account shall be eligible to receive points each year by engaging in targeted health behaviors. Proposed targeted health behaviors could include, but are not limited to, no emergency department use for ambulatory care conditions that could have been treated in a primary care doctor's office, completion of an annual Health Risk Assessment, and an annual physical examination by a primary care doctor. Beneficiaries will receive consumer report cards about their own health care utilization encouraging the use of services aimed at prevention and wellness. The CHOICES module will provide beneficiaries with a periodic report that lists the types of services an individual has used and the costs of those services.

    Subject to Federal approval, the State may establish a program based on incentives: each family member who earns a designated set of points will be eligible for a reward, ranging from a gift card for health-related goods to a premium holiday.

XII. GENERAL REPORTING REQUIREMENTS

65. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX and title XXI set forth in sections XIII and XIV, respectively.

66. **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.

67. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality as set forth in section XV.

68. **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.

69. **Confirmation of CHIP Allotment with the Submission of CHIP State Plan Amendment**s. 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.

70. **Monthly Calls.** CMS shall schedule monthly 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, 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.

71. **Quarterly Operational Reports.** The State must submit quarterly progress reports in the format specified in Attachment F 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 Global Initiative; 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; and

    f) Evaluation and Quality Assurance and Monitoring activities and interim findings.

72. **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 paragraph 71. The State shall submit the draft annual report no later than February 1st of each year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

    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 HCGS waiver assurances. After reviewing the evidence package, the CMS Regional Office will contact the State staff to discuss necessary follow-up activities.

73. **Reporting Requirements Related to the Extended Family Planning Program.**

    a) In each annual report required by paragraph 72, the State shall report the average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancies and their infants.)

    b) In each annual report required by paragraph 72, the State shall report the number of actual births that occur to extended family planning demonstration participants. (Participants include all individuals who obtain one or more covered medical family planning services through the extended family planning program each year.)

    c) The State submitted to CMS base-year fertility rates and a methodology for calculating the base-year fertility rate, which was approved in conjunction with the January 2009 Global Demonstration approval. For purposes of this section, "fertility rate" means birth rate. These rates must:
        i. Reflect fertility rates during Base Year 1994 for women, age 15-44 years, with family incomes at or below 200 percent FPL and ineligible for Medicaid except for pregnancy; and
        ii. Include births paid with Medicaid funds.

    d) At the end of each Demonstration year (DY), a DY fertility rate will be determined for Demonstration participants during that DY.

The base-year fertility rate and the Demonstration year fertility rate will be used to calculate a measure of births averted through the Demonstration using the following formula:

Births Averted = (base-year fertility rate) – (fertility rate of Demonstration participants during DY) X (number of Demonstration participants during DY)

The intent of the extended family planning program is to avert unintended pregnancies in order to offset the cost of family planning services for Demonstration participants.

XIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

74. **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 XV.

75. **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.
        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 Narr by Demonstration year.

c) For each Demonstration year, twenty-four (24) 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 brackets. Expenditures should be allocated to these forms based on the guidance found below.

i. **Budget Population 1:** [ABD no TPL] Aged, blind, and disabled individuals with no third party liability.

ii. **Budget Population 2** [ABD TPL]**:** Aged, blind, and disabled individuals with third party liability.

iii. **Budget Population 3** [RIte Care]**:** Parents, caretaker relatives, pregnant women, and children.

iv. **Budget Population 4** [CSHCN]**:** Children with special health care needs.

v. **Budget Population 5** [EFP]**:** Postpartum Medicaid eligibles receiving family planning only services.

vi. **Budget Population 6a** [Pregnant expansion]: Uninsured pregnant women of any age from 185% to 250% of the FPL without third party liability or other coverage in the event that title XXI funding is exhausted.

vii. **Budget Population 6b** [Pregnant expansion]**:** Pregnant women from 185% to 250% FPL with third party liability (TPL) or other coverage.

viii. **Budget Population 7** [CHIP Children]**:** Optional targeted low-income children ages 8 through 18 above 100% to 250% of the FPL.

ix. **Budget Population 8** [*substitute care*]: Children and families in managed care (children under 19 & parents). Parents pursuing behavioral health treatment with children temporarily in State custody with income up to 200% of the FPL.

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

xi. **Budget Population 10** [Elders 65 and over]: At risk for LTC with income at or below 200% of the FPL who are in need of home and community-based

services (State only group).

xii. **Budget Population 11**: 217-like Categorically Needy Individuals receiving HCBW-like services & PACE-like participants Highest need group.

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

xiv. **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.

xv. **Budget Population 14 [BCCTP]**: Women screened for breast or cervical cancer under CDC program and not eligible for Medicaid.

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

xvii. **Budget Population 16 [Uninsured adults with mental illness]:** Services for uninsured adults with mental illness and or substance abuse problems with incomes below 200 % of the FPL not eligible for Medicaid.

xviii. **Budget Population 17 [Youth at risk for Medicaid]:** Coverage of detection and intervention services for at-risk young children not eligible for Medicaid up to 300 % of SSI.

xix. **Budget Population 18 [HIV]:** Persons living with HIV with incomes below 200 percent of the FPL who are ineligible for Medicaid.

xx. **Budget Population 19 [Non-working disabled adults]:** Non-working disabled adults ages 19-64 eligible for the General Public cash assistance program, but who do not qualify for disability benefits.

xxi. **Budget Services 1** [Windows]**:** Cost of replacement windows in residences of lead-poisoned eligibles.

xxii. **Budget Services 2** [RIteShare & Collctns]**:** Premiums paid by State for ESI coverage and premiums paid by RIteCare enrollees.

xxiii. **Budget Services 3** [Other Payments]: Payments to health plans for performance incentives; risk sharing; and stop loss, as well as FQHC supplemental payments.

xxiv. **Budget Services 4 [Core and Preventive Services]:** Core and preventive services for Medicaid-eligible at-risk youth.

xxv. **Budget Services 5**: Services billed to the Rhode Island Department of Health by the FQHCs for providing a limited benefit package for uninsured individuals.

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 69.

76. **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 75. 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.

77. **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.

78. **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.

79. **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.

80. **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 71, the actual number of eligible member months for the budget Populations defined in paragraph 74(c)(i-xix). The 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.

81. **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.

82. **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 XV:

    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.

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

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.

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.

e) Rhode Island will provide to CMS an updated list of Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding Systems (HCPCS) codes covered under the Demonstration on January 31 of each Demonstration year. The revised code list should reflect only changes due to updates in service codes for those services for which the State has already received approval.

f) Changes to services listed in Attachment C will require an amendment to the Demonstration in accordance with paragraph 17 of these STCs.

84. **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.

85. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

XIV. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

86. **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).

87. **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.

88. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. Rhode Island must estimate matchable expenditures for CHIP Children 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.

89. **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 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 6a 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 6a 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 17(b) and notify CMS of its intent to exercise its authority to cover Population 6a using title XIX funds. When title XXI funds are exhausted Population 6a derives its eligibility through the costs not otherwise matchable authority under the Demonstration and will be considered a title XIX expenditure. The State is at risk for ensuring that payments for Population 6a will not exceed the budget neutrality aggregate cap.

90. **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.

XV. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

The following describes the method by which budget neutrality will be assured under the Demonstration. The Demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The STCs specify the aggregate financial cap on the amount of

Federal title XIX funding that the State may receive on expenditures subject to the budget neutrality cap as specified in paragraph 76 of section XIII. The budget neutrality cap will be for the Federal share of the total computable cost of $12.075 billion for the 5-year demonstration period. The cap places the State at risk for enrollment and for per participant month cost trends.

91. **Limit on Title XIX Funding**. The limit defined above will apply to actual expenditures for the Demonstration period, as reported by the State under section XIII. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in section XIII, paragraph 75. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

    The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the composite Federal share. The composite Federal share is the ratio calculated by dividing the sum total of 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 and pharmacy rebates) by total computable Demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for extended family planning program must be subtracted from the numerator and denominator, respectively, prior to calculation of this ratio. 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.

92. **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 exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target (Total Computable Cost)*	Cumulative Target Definition	Percentage
Year 1	$2.6 Billion	Year 1 budget estimate plus	8.0 percent
Year 2	$5.0 Billion	Years 1 and 2 combined budget estimate plus	3.0 percent
Year 3	$7.3 Billion	Years 1 through 3 combined budget estimate plus	1 percent
Year 4	$9.7 Billion	Years 1 through 4 combined budget estimate plus	0.5 percent

Demonstration Year	Cumulative Target (Total Computable Cost)*	Cumulative Target Definition	Percentage
Year 5	$12.075 Billion	Years 1 through 5 combined budget estimate plus	0 percent

*****The cumulative target includes the percentage margin.

In addition, the State may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the Demonstration will exceed the cap during this initial approval period.

93. **Exceeding Budget Neutrality**. If the 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, the budget neutrality test shall be based on the time elapsed through the termination date.

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

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

a) Rhode Island Global. At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the entire Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. The evaluation must address the adequacy and appropriateness of the benefit coverage, safety and outcome of the LTC reform and expansion groups, especially the extended Family Planning, HIV Services, Elders 65 and Over and Parents pursuing behavioral health services expansion groups. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

b) Focused Evaluations. The separate components of the demonstration that must be evaluated include, but are not limited to, the following:

a) LTC Reform, including the HCBS-like and PACE-like programs;

b) RIte Care;
c) Rite Share;
d) The section 1115 Expansion Programs (Limited Benefit Programs), including but not limited to:
   (1) Children and Families in Managed Care and Continued eligibility for Rite Care parents when kids are in temporary State custody;
   (2) Children with Special Health Care Needs;
   (3) Elders 65 and Over;
   (4) HCBS for Frail Elders, HCBS for adults with disabilities, HCBS for Kids in residential diversion and HCBS for at risk/Medicaid eligible youth;
   (5) Uninsured adults with mental illness/substance abuse problems;
   (6) Coverage of detection and intervention services for at risk young children;
   (7) HIV Services;
   (8) Administrative Process flexibility; and
   (9) Extended Family Planning Program. The State submitted the draft design for the extended family planning program. The final report should also include an integrated presentation and discussion of the specific evaluation questions (including those that focus specifically on the target population for the family planning program) that are being tested. At a minimum, the following data elements will be included in the measurement methodology:

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

95. **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.

96. **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.

97. **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.

98. **Quality Assurance and Improvement** – The State shall keep in place the existing quality systems for the waivers/demonstrations/programs that currently exist and will remain intact under the Global 1115 (RIte Care, Rhody Health, Connect Care Choice, RIte Smiles, and PACE). For its Home and Community Based Services System under the Global 1115, the State will utilize a QA/QI plan consistent with the Quality rubric utilized in the CMS section 1915(c) waiver program that will assure the health and welfare of program participants. This QA/QI system will be based on the system utilized in the current aged/disabled waiver, number 0040.90.R5. Components must be added to the QA/QI to monitor and evaluate the health and welfare of the section 1115 expansion programs with limited benefit coverage.

XVII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Date - Specific	Deliverable	STC Reference
7/1/2009	Submit Draft Evaluation Plan, including Evaluation Designs for RIte Care and the Extended Family Planning program	Section XVI, paragraph 94
12/31/2012	Submit Demonstration Extension Request	Section III, paragraph 6
12/31/2012	Submit Interim Evaluation Report	Section XVI, paragraph 95

	Deliverable	STC Reference
Annual	By January 31st – Updated Family Planning Codes	Section XIII, paragraph 83
	By February 1st - Draft Annual Report	Section XII, paragraph 72
Quarterly	CHIP Enrollment Reports	Section XII, paragraph 68
	Operational Reports	Section XII, paragraph 71
	Title XIX Expenditure Reports	Section XII, paragraph 74
	Title XXI Expenditure Reports	Section XIV, paragraph 86
	Eligible Member Months	Section XIII, paragraph 80

ATTACHMENT A
Services[3]

State Plan Services as of 11/1/2008

Service	Description
Inpatient Hospital Services	Mandatory 1905(a)(1)
Outpatient Hospital Services	Mandatory 1905(a)(2)
Rural health clinic services	Mandatory 1905(a)(2)
FQHC services	Mandatory 1905(a)(2)
Laboratory and x-ray services	Mandatory 1905(a)(3)
Diagnostic Services	Optional 1905(a)(13)
Nursing Facility Services for 21 and over	Mandatory 1905(a)(4)
EPSDT	Mandatory 1905(a)(4)
Family Planning	Mandatory 1905(a)(4)
Physicians' services	Mandatory 1905(a)(5)
Medical and Surgical services furnished by a dentist	Mandatory 1905(a)(5)
Podiatrists' services	Optional 1905(a)(6)
Optometrists' services	Optional 1905(a)(6)
Intermittent or part-time nursing services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
Home health aide services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
Medical supplies, equipment, and appliances	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
Physical therapy; occupational therapy; speech pathology; audiology provided by a home health agency	Optional 1902(a)(10)(D) 42 CFR 440.70
Clinic Services	Optional 1905(a)(9)
Dental Services	Optional 1905(a)(10)
Prescribed Drugs	Optional 1905(a)(12)
Non-Prescription Drugs	Optional 1927(d)
Dentures	Optional 1905(a)(12)
Prosthetic Devices	Optional 1905(a)(12)
Eyeglasses	Optional 1905(a)(12)
Preventive Services	Optional 1905(a)(13)
Rehabilitative Services	Optional 1905(a)(13)
Services for individuals over age 65 in IMDs	Optional 1905(a)(14)
Intermediate Care Facility Services	Optional 1905(a)(15)
Inpatient psychiatric facility services for under 22	Optional 1905(a)(16)

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

Nurse-midwife services	Mandatory 1905(a)(17)
Hospice Care	Optional 1905(a)(18)
Case Management Services and TB related services	Optional 1905(a)(19)
Extended services for pregnant women	Optional 1902(e)(5)
Certified pediatric or family nurse practitioners' services	Mandatory 1905(a)(21)
Nursing facility services for patients under 21	Optional 1905(a)(28) 42 CFR 440.170
Personal care services in recipient's home	Optional 1905(a)(28) 42 CFR 440.170
Transportation	Optional as a medical service section 1905(a)(28)- 42 CFR 440.170 required as an administrative function 42 CFR 431.53
Primary care case management services	Optional 1905(a)(25)
PACE services	Optional 1905(a)(26)
Emergency services for certain legalized aliens and undocumented aliens	Mandatory 1903(v)(2)(A)

ATTACHMENT A1
RIte Care Demonstration Only Benefits

These benefits are not provided under the Rhode Island Medicaid State Plan, but only under the Demonstration.

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

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

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

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

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

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

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

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

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

Supported Employment: Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by

an individual receiving waiver services as a result of his/her disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

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

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

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

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

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

Senior Companion (Adult Companion Services): Non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry, and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan of care.

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

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

Personal Care Assistance Services: Personal Care Assistance Services provide direct support in the home or community to an individual in performing tasks that he/she is functionally unable to complete independently due to disability, based on the Individual Service and Spending Plan. Personal Care Assistance Services include:

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

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

Respite: Respite can be defined as a service provided to a participant unable to care for himself/herself that is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. FFP is not claimed for the cost of room and board because all respite services under this waiver are provided in a private home setting, which may be in the participant's home or occasionally in the respite provider's private residence, depending on family preference and case-specific circumstances. When an individual is referred to a DHS-certified respite agency, a respite agency staff person works with the family to assure that they have the requisite information and/or tools to participate and manage the respite services.

The individual/family will already have an allocation of hours that has been recommended and approved by DHS. These hours will be released in 6-month increments. The individual/family will determine how they wish to use these hours. Patterns of potential usage might include: intermittent or occasional use; routine use of a few hours each week; planned weekends away; a single block of hours that might allow the rest of the family to spend a few days together, or some combination of the above. The individual's/family's plan will be incorporated into a written document that will also outline whether the individual/family wants help with recruitment, the training needed by the respite worker, the expectations of the individual/family relative to specific training and orientation to the home, and expectations relative to documenting the respite worker's time. Each participant in the waiver may receive up to 100 hours of respite services in a year. Additional hours may be available for urgent situations, at the discretion of DHS.

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 because of the absence or need for relief of those persons normally providing the care. Respite services can be provided in the individual's home or in a facility approved by the State, such as a hospital, nursing facility, adult day services center, foster home, or community residential facility. An individual qualifies for these respite services if he/she requires the services of a professional or qualified technical health professional or requires assistance with at least two activities of daily living.

ATTACHMENT C
Family Planning Codes

The following procedure codes are considered family planning services as noted below:

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
00851	Tubal ligation / transection	✓		
11975	Insertion, implantable contraceptive capsules	✓		
11976	Removal, implantable contraceptive capsules		✓	
11977	Removal w/ reinsertion, implantable contraceptive capsules	✓		
57170	Diaphragm or cervical cap fitting w/ instructions	✓		
58300	Insertion of intrauterine device (IUD)	✓		
58301	Removal of intrauterine device (IUD)		✓	
58600	Ligation or transection of fallopian tubes	✓		
58611	Ligation or transection of fallopian tubes	✓		
58615	Occlusion of fallopian tubes by device	✓		
58670	Laparoscopy, surgical; w/fulguration of oviducts (w/ or w/out transection)	✓		
58671	Laparoscopy, surgical; w/occlusion of oviducts by device (e.g., band, clip, etc.)	✓		
81000	Urinalysis, by dipstick or reagent for bilirubin, glucose, hemoglobin, etc.		✓	
81002	Urinalysis, non-automated without microscopy		✓	
81003	Urinalysis, automated, without microscopy		✓	
81005	Urinalysis; qualitative or semiqualitative, except immunoassays		✓	
81007	Urinalysis, bacteriuria screen, except by culture or dipstick		✓	
81015	Urinalysis, microscopic only		✓	
81020	Urinalysis, two or three glass test		✓	
81025	Urine pregnancy test, by visual color comparison methods		✓	
85013	Blood count; spun microhematocrit		✓	
85014	Blood count; other than spun microhematocrit		✓	
85018	Blood count; hemoglobin		✓	
86255	Fluorescent antibody; screen, each antibody		✓	
86592	Syphilis test; qualitative (e.g., VDRL, RPR, ART)		✓	
85693	Syphilis test; quantitative		✓	
86631	Antibody; Chlamydia		✓	
86632	Antibody; Chlamydia, IgM		✓	
86689	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)		✓	
86694	Antibody; herpes simplex, non-specific type test		✓	
86695	Antibody, herpes simplex, type 1		✓	
86701	Antibody; HIV-1		✓	
86702	Antibody; HIV-2		✓	
86703	Antibody; HIV-1 and HIV-2, single assay		✓	

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
86781	Antibody; Treponema Pallidum, confirmatory test (e.g., FTA-abs)		✓	
87081	Culture, bacterial, screening only, for single organisms		✓	
87110	Culture, chlamydia		✓	
87206	Smear, primary source, w/ interpretation; fluorescent &/or fast stain		✓	
87207	Smear, primary source, w/ interpretation; special stain (e.g., malaria, herpes)		✓	
88141	Cytopathology, cervical or vaginal (any reporting system) physician interp.		✓	
88142	Cytopathology, cervical or vaginal (any reporting system) thin prep		✓	
88143	Cytopathology, with manual screening and rescreening under physician supervision		✓	
88147	Cytopathology smears, cervical or vaginal; screening in automated system		✓	
88148	Cytopathology, screening by automated system with manual rescreening - phys. supervis.		✓	
88150	Cytopathology, slides, cervical or vaginal; manual screening - phys. supervis.		✓	
88155	Cytopathology, slides, cervical or vaginal; definitive hormonal evaluation		✓	
88164	Cytopathology, slides, cervical or vaginal; (Bethesday System)		✓	
88165	Cytopathology, with manual screening and rescreening - phys supervis.		✓	
88166	Cytopathology, with manual screening and computer-assisted rescreening - phys supervis.		✓	
88167	Cytopathology, with manual screening and computer-assisted rescreening - cell selection		✓	
88302	Level II Surgical Pathology		✓	
99201	New Patient - Office or other outpatient visit		✓	
99202	New Patient - Office or other outpatient visit		✓	
99203	New Patient - Office or other outpatient visit		✓	
99204	New Patient - Office or other outpatient visit		✓	
99205	New Patient - Office or other outpatient visit		✓	
99211	Established Patient - Office or other outpatient visit		✓	
99212	Established Patient - Office or other outpatient visit		✓	
99213	Established Patient - Office or other outpatient visit		✓	
99214	Established Patient - Office or other outpatient visit		✓	
99215	Established Patient - Office or other outpatient visit		✓	
J0530	Injection, penicillin G benzathine and penicillin G procaine, up to 600,000 units			✓
J0540	Injection, penicillin G benzathine and penicillin G procaine, up to 1,200,000 units			✓
J0550	Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units			✓
J0560	Injection, penicillin G benzathine, up to 600,000 units			✓
J0570	Injection, penicillin G benzathine, up to 1,200,000 units			✓
J0580	Injection, penicillin G benzathine, up to 2,400,000 units			✓
J0690	Injection, cefazolin sodium, 500 mg			✓

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
J0694	Injection, cefoxitin sodium, 1 g			✓
J0696	Injection, ceftriaxone sodium, per 250 mg			✓
J0697	Injection, sterile cefuroximr sodium, per 750 mg			✓
J0698	Cefotaxime sodium, per g			✓
J0710	Injection, cephapirin sodium, up to 1 g			✓
J0715	Injection, ceftizoxime sodium, per 500 mg			✓
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg	✓		
J1850	Injection, kanamycin sulfate, up to 75 mg			✓
J1890	Injection, cephalothin sodium, up to 1 g			✓
J3000	Injection, streptomycin, up to 1 g			✓
J3260	Injection, tobramycin sulfate, up to 80 mg			✓
J3320	Injection, spectinomycin dihydrochloride, up to 2 g			✓
J3370	Injection, vancomycin HC1, 500 mg			✓
S0610	Annual GYN - new patient		✓	
S0612	Annual GYN - established patient		✓	
99395	Comprehensive Preventive Medicine Reevaluation		✓	
00008257602	Alesse-28	✓		
00555904358	Apri	✓		
51285057628	Apri	✓		
00555906658	Aranelle	✓		
00555906667	Aranelle	✓		
00555904558	Aviane	✓		
51285001728	Aviane	✓		
00555071558	Camila	✓		
00062325002	Conceptrol	✓		
00536999512	Condoms	✓		
00555904958	Cryselle	✓		
00052028306	Cyclessa	✓		
00009074630	Depo-Provera	✓		
00009737604	Depo-Provera	✓		
00009470901	Depo-Subq Provera 104	✓		
00052026106	Desogen	✓		
11926022112	Encare	✓		
50486022112	Encare	✓		
00555904758	Enpresse	✓		
00555034458	Errin	✓		
00071092815	Estrostep FE	✓		
00071092847	Estrostep FE	✓		
00430057014	Estrostep FE	✓		

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
02340012800	Extra Sensitive	✓		
00062318012	Gynol II	✓		
00062318501	Gynol II Extra Strength	✓		
52544089228	Jolivette	✓		
00555902557	Junel	✓		
00555902742	Junel	✓		
00555902757	Junel	✓		
00555902658	Junel FE	✓		
00555902858	Junel FE	✓		
00555905058	Kariva	✓		
00555906467	Kelnor 1/35	✓		
08137008908	K-Y Plus	✓		
00555901458	Lessina	✓		
00555901467	Lessina	✓		
52544027928	Levora-28	✓		
70907001312	Lifestyles	✓		
00008251402	Lo/Ovral -28	✓		
51285007997	Loestrin	✓		
00430053014	Loestrin 24 FE	✓		
51285008370	Loestrin FE	✓		
52544084728	Low-Ogestrel	✓		
52544094928	Lutera	✓		
00703680101	Medroxyprogesterone Acetate	✓		
00703681121	Medroxyprogesterone Acetate	✓		
59762453701	Medroxyprogesterone Acetate	✓		
52544095021	Microgestin	✓		
52544095121	Microgestin	✓		
52544063028	Microgestin FE	✓		
52544063128	Microgestin FE	✓		
00052028106	Mircette	✓		
51285011458	Mircette	✓		
52544052628	Mononessa	✓		
52544055028	Necon	✓		
52544055228	Necon	✓		
52544055428	Necon	✓		
52544055628	Necon	✓		
52544093628	Necon	✓		
52544062928	Nora-Be	✓		
51285009158	Nordette-28	✓		

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
00555900858	Nortrel	✓		
00555900867	Nortrel	✓		
00555900942	Nortrel	✓		
00555901058	Nortrel	✓		
00555901258	Nortrel	✓		
00052027301	Nuvaring	✓		
52544084828	Ogestrel	✓		
00062192001	Ortho-evra	✓		
00062192015	Ortho-evra	✓		
00062141116	Ortho Micronor	✓		
00062190315	Ortho Tricyclen	✓		
00062125115	Ortho Tricyclen LO	✓		
00062190115	Ortho-Cyclen	✓		
00062330400	Ortho-Diaphragm	✓		
00062330500	Ortho-Diaphragm	✓		
00062330600	Ortho-Diaphragm	✓		
00062334500	Ortho-Diaphragm	✓		
00062176115	Ortho-Novum	✓		
00062178115	Ortho-Novum	✓		
00430058014	Ovcon-35	✓		
00430058114	Ovcon-35	✓		
00430058214	Ovcon-35	✓		
00430058514	Ovcon-50	✓		
51285003893	Plan B	✓		
64836000001	Plan B	✓		
00555902058	Portia	✓		
00093531628	Previfem	✓		
00093531681	Previfem	✓		
52544095428	Reclipsen	✓		
51285005866	Seasonale	✓		
66993061128	Solia	✓		
00555901658	Sprintec	✓		
50419043303	Tri-Levlen 28	✓		
52544093528	Trinessa	✓		
00008253601	Triphasil-28	✓		
00093531528	Tri-Previfem	✓		
00093531581	Tri-Previfem	✓		
00555901858	Tri-Sprintec	✓		
52544029128	Trivora-28	✓		

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
22600064712	Trojan	✓		
22600090750	Trojan	✓		
22600090950	Trojan	✓		
22600092050	Trojan	✓		
22600093850	Trojan	✓		
22600095000	Trojan	✓		
22600095250	Trojan	✓		
22600095850	Trojan	✓		
22600097250	Trojan	✓		
22600091750	Trojan Enz	✓		
22600093050	Trojan Enz	✓		
22600093150	Trojan Enz	✓		
22600093250	Trojan Enz	✓		
22600093270	Trojan Enz	✓		
22600093350	Trojan Enz	✓		
22600093750	Trojan Enz	✓		
22600093770	Trojan Enz	✓		
22600093950	Trojan Enz	✓		
22600064212	Trojan Magnum	✓		
22600064512	Trojan Magnum	✓		
22600098050	Trojan Natural Lamb	✓		
22600098750	Trojan Natural Lamb	✓		
22600094550	Trojan Ribbed	✓		
22600094750	Trojan Ribbed	✓		
22600094950	Trojan Ribbed	✓		
22600092240	Trojan Very Sensitive	✓		
22600092340	Trojan Very Sensitive	✓		
22600092640	Trojan Very Thin	✓		
22600092740	Trojan Very Thin	✓		
48723000111	VCF	✓		
52925011201	VCF	✓		
52925031214	VCF	✓		
00555905158	Velivet	✓		
00555905167	Velivet	✓		
50419040203	Yasmin 28	✓		
50419040503	Yaz	✓		
52544038328	Zovia 1/50E	✓		
52544038428	Zovia 1/50E	✓		

ATTACHMENT D
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.

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 Department of Human Services (RI-DHS);
- 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 RI-DHS 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 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.

ATTACHMENT E
Level of Care Criteria

Long-term Care Level of Care Determination Process

With and Without the RI Global Compact Waiver

Attached are: (1) A chart comparing the level of care determination process with and without the section 1115a Global Compact 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 Global Compact Demonstration.

<table>
<tr><th colspan="6">Level of Care Determination Process: With and Without the Global Compact Waiver</th></tr>
<tr><th colspan="3">Current Level of Care Determination</th><th colspan="3">LTC Level of Care and Service Option Matrix</th></tr>
<tr><td rowspan="4">Nursing Home Level of Care

(Access to Nursing Facilities and section 1915(c) HCBS waivers – scope of Community-based Services varies depending on waiver)</td><td rowspan="4">Hospital Level of Care

(Access to Long-term Care, Hospital, Residential Treatment Centers and HAB waiver Community-based Services)</td><td rowspan="4">ICFMR Level of Care

(Access to ICFMR, and section 1915(c) HCBS waivers MR/DD Community-based Services)</td><td>Highest Nursing Home Level of Care

(Access to Nursing Facilities and all Community-based Services)</td><td>Highest Hospital Level of Care

(Access to Hospital, Group Homes, Residential Treatment Centers and all Community-based Services)</td><td>Highest ICFMR Level of Care

(Access to ICFMR, Group Homes and all Community-based Services)</td></tr>
<tr><td>High Nursing Home Level of Care

(Access to Core and Preventive Community-based Services)</td><td>High Hospital Level of Care

(Access to Core and Preventive Community-based Services)</td><td>High ICFMR Level of Care

(Access to Core and Preventive Community-based Services)</td></tr>
<tr><td>Preventive Nursing Home Level of Care
(Access to Preventive Community-based Services)</td><td>Preventive Hospital Level of Care
(Access to Preventive Community-based Services)</td><td>Preventive ICFMR Level of Care
(Access to Preventive Community-based Services)</td></tr>
</table>

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. A 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.

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	

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
2^{nd} or 3^{rd} Degree Burns	Suctioning
Gait evaluation and training	

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, 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	

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

High Need Group

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

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.

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 because of the absence or need for relief of those persons normally providing the care. Respite services can be provided in the individual's home or in a facility approved by the State, such as a hospital, nursing facility, adult day services center, foster home, or community residential facility. An individual qualifies for these respite services if he/she requires the services of a professional or qualified technical health professional or requires assistance with at least two activities of daily living.

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 F
Quarterly Progress Report Template and Instructions

As stated in Special Terms and Conditions paragraph 72, 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.)***

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****
(N*ame of individual State eligibility groups*)			
(N*ame of individual State eligibility groups*)			
(N*ame of individual State eligibility groups*)			

*Voluntary Disenrollments:
Cumulative Number of Voluntary Disenrollments Within Current Demonstration Year:
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	Description of Item/Service (if not self-explanatory)	Total Cost
10	Microwaves		$1,000.89
1	Water Therapy	Aqua massage therapy that will assist	$369.00

# of Units/ Items	Item or Service	Description of Item/Service (if not self-explanatory)	Total Cost
		individual with motor function.	
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

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. Evaluation/Quality Assurance/Monitoring Activity

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

XI. Enclosures/Attachments

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

XII. State Contact(s)

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

XIII. Date Submitted to CMS

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

XIV. Budget Neutrality Monitoring Format

Refer to the Microsoft Excel spreadsheet at Attachment G to provide individual financial data for State programs.

The State may add additional program headings as applicable.

ATTACHMENT G
Interim Procedural Guidance – Listing of Types of Evidence

Attachment D

HCBS Quality Review Work Sheet

I. Level of Care (LOC) Determination

The State demonstration that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/MR.

Sub Assurances	CMS Expectations	Types of Evidence
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 application files to verify that individual level of care evaluations are conducted.	Summary reports 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 observation, 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 ✓ Critical events and incident reports ✓ Mortality reviews ✓ Program logs ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Presentation of policies or procedures Reports to State Medicaid Agency on delegated administrative functions Other
The level of care of enrolled participants is reevaluated at least annually or as specified in its approved waiver.	State submits evidence that it regularly reviews participant files to verify that reevaluations of level of care are conducted at least annually 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 waiver is used in all level of care re-determinations, the person(s) who implement level of care determinations are those specified in approved waiver, and the process/instrument are applied appropriately.	

II. Service Plans

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub Assurances	CMS Expectations	Types of Evidence
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 periodically to assure that all of participant needs are addressed and preferences considered.	Summary reports 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 observation, 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 ✓ Critical events and incident reports ✓ Mortality reviews ✓ Program logs ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Reports to Stat Medicaid Agency on delegated administrative functions Presentation of policies or procedures Other
The state monitors service plan development in accordance with its policies and procedures.	State submits evidence of its monitoring process for service plan development and any corrective action taken when service plans were not developed 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 when a participant's needs changed and corrective actions taken when service plans were not updated/revised according to policies and procedures.	

Service Plans (Continued)

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.		
Sub Assurances	**CMS Expectations**	**Types of Evidence**
Services are delivered in accordance with the service plan, including in 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.	Summary reports 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 observation, 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 ✓ Critical events and incident reports ✓ Mortality reviews ✓ Program logs ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Reports to Stat Medicaid Agency on delegated administrative functions Presentation of policies or procedures Other
Participants are afforded choice: 1) Between waiver services and institutional care; and 2) Between/among waivers services and providers.	State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.	

III. Qualified Providers

The State demonstrates it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.		
Sub Assurances	**CMS Expectations**	**Types of Evidence**
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 services.	State provides documentation of periodic review by licensing/certification entity.	Summary reports 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 observation, 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 ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Reports to Stat Medicaid Agency on delegated administrative functions Presentation of policies or procedures Other
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

The state demonstrates, on an ongoing basis that is identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.		
Sub Assurances	CMS Expectations	Types of Evidence
The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	State demonstrates that, on an ongoing basis, abuse, neglect and exploitation 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 strategies it has implemented for prevention.	Summary reports 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 observation, 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 ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Reports to Stat Medicaid Agency on delegated administrative functions Meeting minutes Presentation of policies or procedures Other

V. Administrative Authority

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.		
Sub Assurances	CMS Expectations	Types of Evidence
The Medicaid agency retains 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 institute when problems are identified in the operation of the waiver program.	Summary reports 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 observation, 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 ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Meeting minutes Reports to Stat Medicaid Agency on delegated administrative functions Presentation of policies or procedures Other

VI. Financial Accountability

The State demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.		
Sub Assurances	**CMS Expectations**	**Types of Evidence**
Some financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	State submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in 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 agreements/contracts.	Summary reports 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 observation, 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 ✓ Medication administration data reports, logs ✓ Financial records (including expenditures) Financial audits Reports to Stat Medicaid Agency on delegated administrative functions Meeting minutes Presentation of policies or procedures Other