Appendix A

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

The Rhode Island 1115 Waiver Extension Request

March 2013

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ATTACHMENTS

SECTION I. PROGRAM DESCRIPTION

Purpose, Goals, and Objectives

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

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

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

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

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

The federal funding certainty was designed as a cap or limit on the amount of spending the federal government would be expected to provide. Overall spending on the five-year Demonstration was capped at $12.075 billion. This budget neutrality arrangement was different than Rhode Island's budget neutrality agreements in previous 1115 Waivers in that it was not enforced on an annual basis and, more importantly, it placed the State at risk for enrollment or caseload as well as per participant per month cost trends.

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

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

[3] http://www.newenglandcouncil.com/assets/RI-Executive-Summary.pdf

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

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

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

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

Administrative Simplification

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

Consumer Empowerment and Choice
Personal Responsibility

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

Community-based care solutions

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

Prevention, Wellness and Independence

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

Competition

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

Pay for Performance

- Managed Care Contracting Provisions

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

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

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

   We were unable to successfully implement a selective contracting approach to durable medical equipment. We sought to implement selective contracting as a blunt tool focused solely on lowest price. True payment reform requires a more comprehensive approach in which selective contracting is implemented as part of an overall strategy to ensure care and services are delivered in the most cost-effective manner.

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

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

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

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

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

The managed care approaches we have implemented have added value to the system. Greater value can be realized by more closely joining the approach with person-centered care and point of delivery system enhancements such as the patient centered medical home, integrated primary and behavioral health care, all payer collaboratives, cross provider teams, transition management and alignment of incentives in payment reform.

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

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

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

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

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

One of the major goals of the ACA is to ensure as many people as possible have access to and avail themselves of affordable coverage. EOHHS intends to seek General Assembly approval to submit a State Plan Amendment to implement the Medicaid expansion available in the ACA. If approved, adults without dependent children meeting the income guidelines will be Medicaid-eligible in 2014.[4]

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

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

[4] While we intend to extend eligibility to the new expansion population under the State Plan authority, this waiver extension request does seeks authority to enroll the expansion population in our existing managed care delivery system. We have opted to exclude any future expenditure associated with the expansion population from our budget neutrality arrangement. This decision was made primarily because we do not yet have State or Federal authority for the coverage. There is also a great degree of uncertainty on the costs of the new group. We are looking forward to discussing with CMS the appropriate treatment of the new coverage group in our budget neutrality calculations.

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

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

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

Services need to be coordinated across providers and systems. They need to be available and provided timely at the point when they will have the most impact. When we pay directly for services or contract with managed care organizations, we will implement reimbursement methodologies that deliver outcomes, not more services. We need to develop more community-based services such as early identification of persons as they become more vulnerable in the community, Supportive Housing, peer supports and employment supports.

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

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

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

Ensure the Medicaid program is coordinated with other insurance systems

We will **finance health care services** in ways that support the outcomes we are seeking for our beneficiaries. We will pursue financing methodologies in concert with other payers, such as Medicare and commercial insurers, in order to reduce provider burden and impact the overall health care delivery system.

Utilize Information Technology Systems more efficiently

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

We will have a dedicated and active **Quality and Evaluation Office** that will ensure any budget initiative, grant, program, or medical benefit actually achieves the results we are seeking. If it does not, we will stop doing it and paying for it. We will publish those results

on our website and make it easy for people to understand how the State is spending Medicaid dollars and the effectiveness of those efforts. This effort will be supported by our recently received grant to implement quality measures for adult health.

While the ACA does provide many tools to help us achieve our goals, we still need the authority of the 1115 Waiver to continue initiatives and to pursue new efforts. This extension request seeks to continue all existing Waiver and Expenditure Authorities and outlines new initiatives we will be pursuing and the appropriate waiver or expenditure authority requested for implementation.

We are proposing changes in eligibility, benefits, and the delivery system. All the proposed changes are supported by the above guiding principles. None of the changes seek to reduce or curtail access to necessary and appropriate services. The waiver extension seeks to build a Medicaid program that is highly responsive to the needs of the beneficiaries we serve and that through our efforts we contribute to the improvement of the State's overall health care system.

SECTION II. DEMONSTRATION ELIGIBILITY

Rhode Island's Medicaid program plays a critical role in ensuring access to quality health care for low income and vulnerable populations. All of the eligibility groups covered presently by Rhode Island Medicaid are included within the current 1115 waiver. In the waiver extension period EOHHS will continue all of these coverage groups. Covered groups include categorically eligible groups (mandatory and optional), medically needy (mandatory and optional), groups that could be covered under the state plan but are covered under the demonstration, and groups that are covered under the demonstration authority. Pending legislative action, eligibility will be extended to the Medicaid expansion group, adults without dependent children to 133% of FPL. Authority for coverage of this group will be pursued through the state plan rather through this demonstration. Although eligibility authority is not sought through this waiver extension, the delivery system reforms pursued under this extension request will apply.

Rhode Island does seek certain modifications to current eligibility rules. In two instances these are requests for authorities that will smooth implementation of ACA related initiatives. Specifically one of these is to help ensure continuity of care between Medicaid and the Exchange and help ensure the Medicaid program is coordinated with other publicly supported insurance. The second is to extend eligibility for a subset of Medicaid clients who would come up for redetermination between January 1, 2014 and March 31, 2014 by up to three months. This would allow these clients to only need to be re-determined under MAGI rules and eliminate administrative complexities using two different eligibility rule systems.

Additionally, as part of its effort to improve communications and promote comprehensive enrollment, Rhode Island seeks to modify its method of complying with out stationing requirements.

Consistent with our focus on re-balancing, Rhode Island also requests eligibility authority for specific populations to better enable timely intervention for individuals at high risk for institutionalization and/or to facilitate effective transitions to the community. We seek to modify rules for post eligibility treatment of income and for collection of patient liability to better support community based options. We also propose to extend Medicaid eligibility when a person is a detainee in our State correctional facility.

Current Eligibility Groups

The table below summarizes the eligibility groups included within the current waiver. We request that authority for each of these groups will be continued in the extension period. In the table, eligibility groups are displayed in accordance with current rules. The state will comply with the MAGI standards and methodologies for MAGI populations as required under the ACA. The state has completed the draft MAGI conversion template and will adhere to MAGI conversion methodology guidance for all applicable populations. Furthermore, the state will work with CMS to implement the income conversion methodology as required and will follow its Verification Plan and Reasonable Compatibility standards in determining MAGI eligibility.

The State of Rhode Island intends to carry forward all existing eligibility groups from the initial waiver period. Through the State Plan, the state intends to expand Medicaid eligibility for:

- independent former foster children from age 21 to 26 as required by the Affordable Care Act, and
- adults with incomes less than 133% of the Federal Poverty Level, pending authorization from the Rhode Island General Assembly.

Eligibility Groups Under The Approved State Plan As Of November 1, 2008
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 percent 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 percent 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 percent 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 percent 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 percent 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 percent 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 percent 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 percent 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 percent of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Qualified family members §1902(a)(10)(A)(i)(V)	*Income*: Up to 100 percent 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 percent 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 percent 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 percent 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*: *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 percent 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 earning 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 $3,000 couple	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 $3,000 couple	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 percent 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 percent 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 percent but =<120 percent 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 percent 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 percent of FPL *Resource*: No resource test	Budget Population 3 RIte Care
Children under age 1	*Income:* Up to 250 percent 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 percent 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 percent 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 percent of FPL *Resource*: No resource test	Budget Population 4 CSHCN
Individuals who are eligible for but not receiving SSI or State supplement cash assistance §1902(a)(10)(A)(ii)(I)	*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 percent 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 percent 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 percent 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 percent 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	Include elig requirements	Budget Population 14 BCCTP

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 percent 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 percent 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 percent 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 percent 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)[1]	*Income*: 133[1]/3 percent of §1931 income standard *Resource*: Family size 1: $4,000 Family size 2: $6,000 Each additional person: $100	Budget Population 3 RIte Care
Specified relatives of dependent children who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(ii)	*Income*: 133[1]/3 percent 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 percent 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 percent 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 percent 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 percent of SSI Federal benefit level *Resource*: $4,000	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 (b) in private institutions; (2) individuals placed in foster homes or private institutions by private, non-profit agencies; (3) individuals in nursing facilities; and (4) individuals in ICFs/MR.

ELIGIBILITY GROUPS UNDER THE DEMONSTRATION

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

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	*Income*: Above 185% to 250% FPL *Resource*: No resource test	Budget Population 6 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:	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 percent of SSI Resource: no resource limit	Budget Population 9 CSHCN not voluntarily placed in State custody
Individuals 65 and over At risk for LTC who are in need of home and community-based services (state only group).	Income: at or below 200% of the FPL Resource Test: No resource test	Budget Population 10 Elders at risk for LTC
Categorically Needy Individuals under the State Plan receiving HCBW services & PACE-like participants highest need group	Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under 42 CFR 435.217, 435.726 and 435.236 of the federal regulations and section 1924 of the Social Security Act, if the State had 1915(c) waiver programs.	Budget Population 11 217 & PACE like Categorically needy Highest
Categorically needy individuals under the State Plan receiving HCBW services & PACE-like participants High need group	Use institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner as specified under 42 CFR 435.217, 435.236, and 435.726 of the federal regulations and 1924 of the Social Security Act, if the	Budget Population 12 217 & PACE like Categorically needy High

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

Eligibility Changes Sought in Waiver Extension

Eligibility Waiver Request Item #1: Extended eligibility for persons transitioning between Medicaid/CHIP and Qualified Health Plans in the Exchange

The State of Rhode Island seeks to extend Medicaid or CHIP eligibility for persons who are transitioning from Medicaid or CHIP to a Qualified Health Plan (QHP) through the Exchange until enrollment in a QHP begins. Medicaid enrollment typically ends at the end of the month. Enrollment in a QHP occurs either the 1st of the following month or the 1st of the month after that (if eligibility for QHP is determined late in the month). To ensure continuity of care for these individuals during the transition period from Medicaid or CHIP to a QHP, Rhode Island seeks to

extend a person's Medicaid eligibility until enrollment in a QHP begins, so there is no gap in coverage or access to care.

Waiver Authority Sought
Comparability of Eligibility Standards Section 1902(a)(17)

Rationale
The intent of the ACA and of Rhode Island is to ensure that as many people as possible have access to and avail themselves of affordable coverage and to promote continuity of care. The differences between Medicaid and Exchange eligibility rules and processes can leave people without coverage during this transition from Medicaid to the Exchange. This provision will help to address that problem.

Eligibility Waiver Request Item #2: Extend MAGI Medicaid renewals between 1/1/2013-3/31/2014

Description of Change:

Under the Affordable Care Act and subsequent regulations issued on March 23, 2012, Medicaid clients who are eligible prior to December 31, 2013 must not have Modified Adjusted Gross Income financial eligibility rules applied until March 31, 2014 or until they come up for redetermination, whichever is later. The State of Rhode Island seeks a waiver to extend Medicaid eligibility for clients who would come up for redetermination between January 1, 2014 and March 31, 2014 by up to three months. This would allow these clients to only need to be re-determined under MAGI rules and eliminate administrative complexities using two different eligibility rule systems.

Waiver Authority Sought
Waiver of Application of Modified Adjusted Gross Income 1902(e)(14) and CFR 435.603(a)(3)

Rationale: This request is limited in scope, applying to the initial three months of ACA implementation. This will simplify the process of eligibility determination for beneficiaries and avoid unnecessary administrative costs while supporting the goal of ensuring that Medicaid eligibility is streamlined and efficient.

Eligibility Waiver Request Item #3: Expedited LTC Eligibility

Description of Change:

The State is seeking a waiver to accept self-attestation of the financial eligibility criteria for new Long Term Care (LTC) applicants for a maximum of ninety (90) days. Eligible individuals would be required to complete the LTC Clinical and Financial Application for LTC services. After Clinical Eligibility criteria has been verified by the State, the individual would provide a self-attestation of the LTC financial eligibility criteria to receive a limited benefit package of community based LTSS for up to 90 days pending the determination of the full LTC financial application. The limited benefit package would include a maximum of twenty (20) hours weekly

of personal care/homemaker services and/or a maximum of three (3) days weekly of Adult Day Care Services and/or limited skilled nursing services based upon assessment. Upon determination of the approval of the full LTC financial application, the individual would receive the full LTC benefit package. The limited community based LTSS services would be available for up to ninety (90) days or until the eligibility for LTC decision is rendered, whichever comes first. This will provide crucial LTC services for individuals in need of immediate community based services and potentially avoid institutional placement while the full financial application is processed. We seek approval to modify the limited benefit package on a case-by-case basis when additional services may be needed to address a specific individual need.

Waiver Authority Sought
Payment for expenditures to provide coverage in these services for individuals who would not otherwise be eligible for these services.

Rationale
The timely provision of community based LTSS supports can be the defining factor in avoiding preventable hospitalizations and institutionalizations. Under current rules, the opportunity to intervene at the critical point in time is often missed while awaiting completion of the financial application and review. Expedited eligibility with this defined set of services can make the difference in to enabling a person to successfully remain in a community setting, avoiding costly medical interventions such as hospital or nursing home admissions.

Eligibility Waiver Request Item #4: Post Eligibility Treatment of Income
Description of Change:

EOHHS seeks to increase the personal needs allowance for certain persons categorically eligible or eligible as medically needy for Medicaid-funded long-term services and supports. These individuals will have resided in a nursing facility for 90 consecutive days, excluding those days that may have been used for the sole intent and purpose of short term rehabilitation; are transitioning from a nursing facility to a community residence, and are assessed to be unable to afford to remain in the community unless the personal needs allowance is increased.

This would not apply to individuals who are residing in a nursing facility and whose income is being used to maintain a current community residence.

Waiver Authority Sought
Waiver from Section 1902(a)(17) Comparability of eligibility standards.

Rationale
This proposal would reduce the monthly cost share for services and allow the individual to obtain and maintain affordable house in the community.

This initiative is intended to increase nursing home transitions by reducing the monthly cost shares towards services and allowing individuals to obtain and maintain affordable housing in the community.

Eligibility Waiver Request Item #5: Process for Collecting Patient Liability

Description of Change:

Current federal regulations at 42 CFR Subpart H and I require State Medicaid agencies determine a person's cost of care and then deduct that amount from their income. Payments to providers are then decreased by the patient cost of care. The onus is then on the provider to collect those funds.

Through this Waiver Extension request, Rhode Island seeks to build a long-term care system that is more community-based. The current process to decrease provider payments by the patient cost of care becomes more difficult as more providers are involved in service delivery, which often happens when a person moves from a nursing home to the community. When a person is in a nursing home, it is a relatively simple task to deduct the patient liability from one provider. If a person resides in the community, he or she may be receiving services from multiple providers: home health agency; adult day care; assisted living, for example.

This extension request also seeks to build a health care delivery system that is transparent and reduces provider administrative burden. Currently, we are not always notified if a person does not pay their cost of share to the provider. We also know that our LTSS providers spend a considerable amount of time pursuing that patient liability.

As administrators of the program, it is essential that we ensure persons are complying with their eligibility requirements, including the requirement to share in their cost of care. We are also cognizant that providers are not incented to report to us when patient liability is not collected as the consequence would be loss of Medicaid eligibility for their client.

Given the above, we propose a new approach to the collection of patient liability. We propose to collect patient liability in the same manner as we currently collect our monthly premiums for enrollment in our RIte Care product; that is, the State will collect the patient liability directly from the Medicaid eligible individuals. The payments to providers would no longer be adjusted for an individual's cost of care.

The methodology to determine the application of patient income to the cost of care would not change (other than any changes requested as part of this proposal – see above). This change would solely address the process of collection. We believe this change will assist us in identifying those individuals who are not complying with their obligations to share in the cost of care and will enable us to implement tools to recover those funds.

<u>Waiver Authority Sought</u>
The applicable CFR is 42 CFR Subpart H and I. The State seeks to waiver the relevant Sections of the Social Security Act.

Eligibility Waiver Request Item #6: Expand Budget Population 10 [Elders 65 and over] from 200% FPL to 250% FPL

Description of Change:

The intended change would expand the income guidelines for Budget Population 10. Budget Population 10 is an expansion group under the 1115 Demonstration and covers individuals 65 and over at risk for Long Term Care who are in need of home and community-based services. Eligibility is limited to those at or below 200% FPL. We are requesting an increase to those at or below 250% of the FPL.

Waiver Authority Sought
Comparability of Eligibility Standards, Section 1902(a)(17).
Modification of income standard for Budget Population 10.

Rationale
Budget Population 10 serves elders age 65 and older with limited incomes who are frail and at risk for admission to Long Term Care facilities and therefore at risk of becoming high cost Medicaid eligible. Supportive home and community based services delay and prevent hospital admissions and subsequent admissions to Long Term Care facilities that lead to high costs and to Medicaid eligibility. The high costs of hospitalization and nursing home stays quickly consume income, leading to Medicaid eligibility under medically needy provisions. This is the case whether a person's income is 200% of FPL or 250% of FPL. Raising the income ceiling provides a greater opportunity to avoid or delay these events, to promote rebalancing, and to avoid Medicaid costs.

Eligibility Waiver Request Item #7: (new) Budget Population 20 – Adults 19-64 with Alzheimer's Disease or Related Dementia

Description of Change:

The intended change would add a new Budget Population. This Budget Population would include adults aged 19-64 who have been diagnosed with Alzheimer's Disease or a related Dementia as determined by a physician, who are at risk for a Long Term Care admission, who are in need of home and community care services and whose annual income is at or below 250% FPL.

Waiver Authority Sought
Comparability of Eligibility Standards, Section 1902(a)(17)
Establishment of a new Budget Population under 1115 authority.

Rationale
Increasingly, health care providers are diagnosing dementia in younger populations. Currently, Budget Population 10 provides home and community based services to elders aged 65 and older who qualify for the program. This new Budget Population# 21 would provide home and community based services to younger adults, aged 19-64 who are diagnosed with dementia, as

determined by a physician, and are at risk for admission to Long Term Care facilities and Medicaid eligibility, but who are able to remain at home with their spouses or caregivers with affordable and supportive home and community based services. Through services to this population, families will be better able to maximize their resources and to keep their family member with dementia at home for as long as possible with needed supports and services. Addressing the needs of people with dementia and their families addresses a critical need. Presently in Rhode Island a major differentiating factor between those who reside in the community and those who reside in a long term care facility is the presence of a dementia related diagnosis.

Eligibility Waiver Request Item #8: Modification to Budget Population 16

Description of Change:

Budget Population 16 presently consists of "Services for uninsured adults with mental illness and/or substance abuse who are at risk for a hospital level of care". This includes people with incomes up to 200% FPL. EOHHS seeks to make two amendments to this Budget Population. The first is clarify the language to be "services for uninsured or underinsured adults" This is because although individuals may have some insurance coverage, that insurance typically does not cover the specialized mental health and substance abuse services provided via Budget Population 16. These services can be vital in enabling people to maintain employment as well as stable housing arrangements. By ensuring that insured persons below 200% FPL can have access to these services, potentially damaging episodes can be limited and Medicaid eligibility can be prevented. The second change requested is to include in Budget Population 16 adults with mental health illness and substance abuse problems who live in families (a) in which a child is at risk for out-of-home placement and into the protective custody of the Department of Children, Youth and Families (DCYF) or (b) in which a child has already been removed from the home and reunification efforts are occurring.

Waiver Authority Sought
Comparability of Eligibility Standards, Section 1902(a)(17).
Modification of Budget Population 16.

Rationale
Medicaid has a proper role in providing quality health care for eligible populations. However, with targeted services, Medicaid eligibility can be avoided for certain groups. The changes are directed at preventing the need for Medicaid eligibility. Services for mental illness and/or substance abuse can enable adults to maintain employment and for stable housing; and can enable families to avoid out-of-home placement or achieve successful reunification.

Eligibility Waiver Request Item #9: Clarification of Budget Population 17: Coverage of detection and intervention services for at-risk young children not eligible for Medicaid up to 300% of the SSI.

Description of Change:

This population group is inconsistently described within the waiver documents. The language above is from the Waiver authority document, paragraph 5.j. Elsewhere for the eligibility table under paragraph 19, "Specific Eligibility Criteria", Budget Population 17 is described as "children under age 18 who are risk for Medicaid or institutional care not eligible for Medicaid".

EOHHS seeks to clarify that Budget Population 17 is inclusive of children under age 18 who have a special health care need; e.g. Seriously Emotionally Disturbed (SED), behavioral challenges and/or medically dependent conditions, who may be safely maintained at home with appropriate intensive levels of care, including specialized respite services.

Eligibility Waiver Request Item #10: Out-Stationing Eligibility Workers

Description of Change**:**

42 CFR 435.904 sets forth requirements for establishment of outstation locations to process applications for certain low income eligibility groups. Rhode Island seeks to waive the requirement to establish out-stationing in person eligibility workers on safety net locations to process applications for certain low-income eligibility groups. With the implementation of the ACA and the Exchange, Rhode Island is taking affirmative steps to maximize opportunities for eligibility determination. EOHHS asks that these steps be recognized as compliant with the out-stationing requirement.

Waiver Authority Sought
EOHHS seeks a waiver of 42 CFR 435.904

Rationale
EOHHS is currently developing and implementing the requirements of the ACA, in coordination and collaboration with the RI Health Benefits Exchange. Rhode Island is committed to the development of a unified infrastructure to facilitate access to health insurance for all Rhode Islanders including Medicaid and CHIP eligible persons. To that end, Rhode Island is building an Integrated Eligibility System (IES) which will determine eligibility for Medicaid, CHIP, Advanced Premium Tax Credits (APTC) and SHOP.

In accordance with the provisions of the ACA, robust customer service and eligibility assistance is a core component. As a response to this requirement, Rhode Island Medicaid in collaboration with the Health Benefits Exchange proposes the following to meet the eligibility assistance requirement:

- Contact Center – A multi-lingual agency under contract with the State that is available 24/7 with live customer service representatives that assist customers to navigate the Web based eligibility portal. Performance requirements will include ability to communicate via text, email and live chat. The Contact Center will also process mail-in applications.
- Navigator Program – Community based organizations, safety net providers and others will have special web portal access to the IES to assist clients in navigating the

application/eligibility determination process. Training and security requirements with the State will be required for client protection purposes. This will be a joint collaboration between Medicaid, Exchange and Human Services.

- In-Person Assistors – The State will procure a contract with an accountable entity to administer a formal program of face to face customer assistance.

EOHHS firmly believes that these new systems will provide a more streamlined and efficient application process to possible Medicaid/CHIP enrollees then the current out-stationing requirement allows. It is in this effort that EOHHS requests a waiver of the relevant Title XIX provisions that support 42 CFR-435.904.

Eligibility Waiver Request Item #11: Increase Income Level for Extended Family Planning from 200% FPL to 250% FPL (Budget Population 5)

Description of Change**:**

Eligibility for Budget Population 5 pertaining to Extended Family Planning Services is presently limited to persons up to 200% FPL. EOHHS is requesting the income limit be raised to 250%.

Waiver Authority Sought
Modification to Budget Population 5

Rationale
Increasing the FPL level to 250% will align with Rhode Island's current Medicaid coverage of pregnant women to 250%.

Eligibility Waiver Request Item #12: Young Adults Aging out of Katie Beckett (Budget Population 21)

EOHHS seeks to expand coverage to young adults age 19-21 aging out of the Katie Beckett eligibility group with incomes below 250 % of FPL who are otherwise ineligible for Medical Assistance and in need of services and/or treatment for behavioral health, medical or developmental diagnoses. The Family Opportunity Act permits states to establish Medicaid-buy-in programs for children with disabilities if their family income is less than 300% of the federal poverty level. Under these provisions children who are not insured through their parents' coverage or underinsured because their family's private insurance excludes or places limits on essential services can access Medicaid to cover these services.

Waiver Authority Sought
Rhode Island seeks to qualify this group as a Medicaid eligibility group under the waiver.

Rationale
This provision can enable children with disabilities aging out of the Katie Beckett program to maintain continuity of care for services that are essential to their ability to successfully remain in the community.

Eligibility Waiver Request Item #13: Coverage for People Incarcerated pending Disposition of Charges (Budget Population 22)

Description of Change:

The ACA provides that "an individual shall not be treated as a qualified individual [for purposes of purchasing insurance through an exchange], if at the time of enrollment the individual is incarcerated, other than incarceration pending disposition of charges." (PPACA §1312(f)(1)(B)) We have interpreted this language to mean that, until their cases are adjudicated, incarcerated individuals are qualified to enroll in and/or maintain coverage with health plans participating in state health insurance exchanges. Further, these individuals are treated the same under the ACA – i.e., qualified for exchange coverage – whether they are in jail or in the community, on bail or otherwise, pending the disposition of the charges against them. They keep coverage under their insurance plan and ostensibly, that coverage includes payment for services.

Under the ACA, Medicaid beneficiaries who are involved with the criminal justice system are treated differently based on their incarceration status. Beneficiaries who satisfy bail requirements and are released into the community pending disposition of charges can continue to receive Medicaid funded services. By contrast, Medicaid funded services are NOT permitted for otherwise eligible beneficiaries who fail to make bail and/or the conditions required for release to the community; the state is required to pay the full cost for health care services to these individuals even though coverage would be continued for their counterparts covered through a state-health insurance exchange. This difference in policy under the ACA for exchange v. Medicaid covered individuals is inequitable, presents continuity of care issues, and limits the flexibility of the state to address the complex behavioral health and medical needs of many of those in this population prior to or in conjunction with disposition of their cases.

The Waiver Extension Request seeks to extend Medicaid payment for services to otherwise eligible Medicaid beneficiaries who are incarcerated while their cases are pending. This change is consistent with the exception in the ACA allowing similarly situated people covered by state health insurance exchange plan to continue their coverage notwithstanding their detainee status until their cases are adjudicated. Amending the Medicaid waiver to include non-sentenced individuals not only provides them with equal treatment under the law, but also avoids continuity of care issues and affords the state the opportunity to address medical and behavioral health needs before release or sentencing.

SECTION III. DEMONSTRATION BENEFITS

INTRODUCTION

During the current Waiver period, the State administered Demonstration benefits approved by CMS that provided for consumer empowerment, transition to and independence in community living and delayed the need for full Medicaid eligibility and benefits. In the course of the Waiver period, the State learned of unmet needs that were not originally identified in the previous Waiver request. As such the State seeks to amend Demonstration benefits to target critical needs and gaps for certain populations. The following section will address benefits for the most complex and high risk populations so that they may be able to transition to the least restrictive setting, maintain independent community living, and maintain or improve health and wellness.

The intent of this section is to outline the benefits the state is requesting under this Waiver extension. The state seeks the flexibility to provide customized benefit packages to beneficiaries based on medical need, to the extent that those benefits comply with the provisions of this extension. All existing State Plan Amendments and 1115 Waiver Amendments (Category Changes) will remain in-force.

ADDITIONAL DEMONSTRATION BENEFITS REQUESTED

Currently, the state is requesting services that are designed to meet the goals of the Demonstration including Consumer Empowerment and Personal Responsibility for managing health, Community based living, Prevention, Wellness, Independence and Cost Effectiveness. The State seeks to purchase Medicaid services for beneficiaries that are value based and quality driven. Services and supports for the population are expected to minimize additional disease burden, stabilize chronic conditions, increase functional ability, delay the need for full Medicaid eligibility or institutionalization, and enhance consumer satisfaction. A reduction in more intensive and costly services such as emergency department visits and hospitalizations is anticipated. The State looks forward to working with CMS regarding the ability to implement the following benefits during the waiver extension period.

Waiver Request Item #1: Wellness Benefit – Rhode to Wellness

Recent empirical evidence has demonstrated that access to preventive care and opportunities for wellness improvement can have both short- and long-term positive impacts on health outcomes. Medicaid programs have increasingly emphasized prevention and wellness to improve beneficiaries' health and reduce overall health care costs.

This wellness benefit will focus on individuals with certain chronic conditions, who receive primary care from a Patient-Centered Medical Home (PCMH). Involvement from and monitoring by the primary care provider (PCP) is critical to the members' ability to succeed in improved wellness. In concert with the members' PCP, the state's contracted Managed Care Organizations (MCOs) or Connect Care Choice programs for Medicaid's fee-for-service population will identify individuals who would benefit from enrollment in the Rhode to Wellness program. Eligibility for referral to this program will consist of the presence of one or more

chronic conditions, as well as the willingness of the member to seek alternative approaches to managing their chronic condition. Medicaid's Rhode to Wellness program will be managed by a licensed registered nurse or licensed nurse practitioner. Aspects of the program will include:

- Enrollment in self-management classes for asthma, diabetes, etc. (aligning with the Dept. of Health's Chronic Disease Self-Management Programs).
- Weight Management classes (e.g. Weight Watchers®).
- Exercise and Fitness programs.
- Nutritional counseling.
- Integrated pain management, where appropriate.
- Tobacco cessation.
- Assistance with making and keeping necessary preventive health visits (e.g. annual physical exam, cervical exam for women, etc.).

Members who participate in the Rhode to Wellness program may receive rewards for ongoing participation and goal attainment, in the form of gift cards, at a designated intervals and when certain milestones are achieved. EOHHS will work with its' Medical Care Advisory Committee to refine the Rhode to Wellness program and to develop criteria for identifying eligible beneficiaries to refer to the program.

Waiver Authority Sought

EOHHS seeks a waiver of Section 1902(a)(10)(B), amount duration and scope, in order to offer a wellness benefit to only certain individuals and to offer these services in the most cost-effective setting.

This waiver request modifies paragraph 64 of the current STCs called Health Choice Accounts. The state requests to continue this current authority in a modified format, including the authority to establish a wellness program based on incentives.

Rationale

By emphasizing prevention and wellness, these alternative benefits seek to improve beneficiaries' health and reduce overall health care costs through prevention and wellness activities. This request aligns with the waiver extension's guiding principle of ensuring Medicaid-financed services are responsive and appropriate to a person's medical, functional, and social needs.

Rhode Island also requests the ability to pursue this effort in conjunction with a Health Homes State Plan Amendment authority.

Waiver Request Item #2: Alternative Benefits for Specific Populations

Traditional Medicaid benefits do not always meet the needs of certain adults with disabilities and chronic conditions. For people with chronic pain, for example established medical solutions (e.g. injections, narcotics) may result in more serious issues (e.g. chemical addiction). Empirical evidence has demonstrated that access to alternative benefits can result in improved health outcomes, more appropriate use of services for these Medicaid beneficiaries and overall lower

medical expenses. In May 2011, the state began offering an alternative pain management benefit in the form of chiropractic care, acupuncture, and therapeutic massage to certain Medicaid managed care enrollees with chronic pain and high emergency room utilization. The state intends to build on this experience by offering alternative benefits to an expanded group of beneficiaries.

Waiver Authority Sought

The state seeks a waiver of Section 1902(a)(10)(B), amount, duration, and scope in order to offer alternative services to only certain individuals with characteristics amenable to these therapeutic interventions identified, and to offer these services in the most cost-effective setting.

This request seeks to modify paragraph 26 of the existing STCs to add a subparagraph entitled Alternative Benefits.

Rationale

Optimal management of chronic pain will enable individuals covered by Rhode Island Medicaid to achieve more productive lives, improve their quality of life, and decrease the utilization of scarce medical resources and the associated costs.

The principles that shall guide the development of Medicaid's pain management program include:

- Patient oriented care that focuses on the whole person (i.e. mind, body and spirit)
- Employment of evidence-based clinical practice guidelines
- Creation and utilization of an integrated treatment plan that coordinates all appropriate therapeutic approaches and care by health professionals
- Integration of alternative therapies (e.g. chiropractic care, osteopathic manipulation, acupuncture, therapeutic massage) when diagnostically appropriate for individual patients
- Care provided fosters close and ongoing collaboration with Primary Care Providers

This request aligns with the Waiver extension's principles as follows:

- 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
- 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

Providing access to alternative benefits will prevent future health care expenditures on emergency room visits and hospitalizations. This request also aligns with this waiver extension's guiding principle of ensuring Medicaid-financed services are responsive and result in stabilization of chronic conditions and increased ability for functioning and thriving in the community.

Impact of Change

- Populations/Eligibility Group – Adults with identified certain chronic conditions and/or disabilities.
- Benefits – examples include pain management and others will be determined in collaboration with the Medical Care Advisory Committee.
- Delivery System – Fee-for-service and Managed Care.
- Payment – Managed Care through capitation rates, Fee-for-service-To be determined.

Rhode Island requests the ability to pursue this effort in conjunction with a Health Homes State Plan Amendment authority.

Waiver Request Item #3: STOP – Sobering Treatment Opportunity Program

Persons with "Chronic inebriation" are a major source of emergency room utilization. First responders (e.g. police, fire, and rescue) are required to bring inebriated people to hospital emergency rooms, if they are not in police custody for committing a crime. The state is requesting authority to deliver services in an alternative treatment setting, which will provide a combination of short-term recovery programs, detoxification treatments, transitional services, and/or referral arrangements. This program is called the Sobering Treatment Opportunity Program (STOP).

- The immediate goals of detoxification treatments are to provide a safe, supervised withdrawal from drugs of dependence. For alcohol and drug dependent people, removal of drugs from their bodies is indeed part of the detoxification process. However, detoxification alone is not a cure for addiction, and should be seen as a part of a person's overall treatment plan.

- To provide withdrawal that is humane and protects the patient's dignity; a caring staff, a supportive environment, sensitivity to cultural issues, confidentiality, and the selection of appropriate detoxification medication (if needed) are all important to providing humane withdrawal.

A clinical and functional assessment will be performed prior to admission to assure that the client is appropriate for STOP. Screening to identify potential mental health issues will be performed, where appropriate, using an evidence-based suicide/mental health assessment tool.

Licensed clinical staff will be available at the facility to monitor clinical issues and facilitate transfer to the hospital whenever necessary. Peer specialists will be utilized to help engage clients and guide them through the steps of participation, recovery, and ongoing support services in the program. Length of stay in the initial phase of STOP will typically be 48 to 72 hours, with additional time for detoxifications and transitional services.

Once a member has safely progressed from the immediate incident initiating contact with STOP, the center staff will refer the client for detoxification, a transition program, outpatient and/or residential treatment. The STOP peer specialist/sober coach will conduct the appropriate follow

up to coordinate appointments for the client, assist the client in keeping appointments, and assist the client in arrangements for temporary, supportive, and/or permanent housing and employment.

The state is requesting authorization to use member incentives to encourage clients to engage in ongoing substance abuse treatment upon discharge from STOP such as vouchers for food, housing, or clothing.

Waiver Authority Sought
The state seeks a waiver of Section 1902(a)(10)(B), amount, duration, and scope in order to offer this service to only certain individuals identified as chronic inebriates, and to offer these services in an alternative setting.

This extension request seeks to modify paragraph 26 of the current STCs by adding a new subparagraph which would authorize the state to provide STOP services to any qualified Medicaid beneficiary, regardless of delivery system enrollment.

Rationale
Providing access to this type of treatment will prevent future health care expenditures on emergency room visits and hospitalizations. This request also aligns with our guiding principle of 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.

Waiver Request Item #4: Telemedicine Services

The state wants to make telemedicine services available to its Medicaid-eligible populations during the waiver extension period. Telemedicine is the use of telecommunication and information technologies in order to provide clinical health care at a distance through the use of video links, e-mail, telephone, or another telecommunications system to transmit medical information, e.g. in consultations between a clinician and patient. The use of telemedicine is a cost-effective alternative to the more traditional face-to-face, doctor-patient interaction. This interactive telecommunication can achieve significant cost savings for the state by reducing unnecessary emergency department visits, ambulance runs and other transportation expenses. These costs can be reduced without compromising the professional and medical standards of the customary office visit/consultation.

Waiver Authority Sought
EOHHS requests a waiver of section 1902(a)(10)(B), amount, duration, and scope in order to enable the state to offer telemedicine services to Medicaid members regardless of their respective eligibility categories.

This request seeks to modify paragraph 26 of the current STCs to stipulate that telemedicine services are available to any qualified Medicaid beneficiary irrespective of their delivery system enrollment.

Rationale
The use of telemedicine conforms to principles guiding this Waiver Extension request: it will maximize the state's effective utilization of information technology systems as well as to minimize additional disease burden and enhance stabilization of chronic conditions resulting in increased ability for functioning and thriving in the community.

Waiver Request Item #5: Peer Supports/Peer Mentoring

The State of Rhode Island seeks to provide Peer Supports and Mentoring to Medicaid beneficiaries in community-based settings.

Peer support occurs when people provide knowledge, experience, and emotional, social or practical help to each other. It commonly refers to an initiative consisting of trained supporters.

Peer mentoring is a form of mentorship that usually takes place between a person who has lived through a specific experience (Peer Mentor) and a person who is new to that experience (the Peer Mentee). Peer Mentors are used for health and lifestyle changes. For example, clients, or patients, with support from peers, may have one-on-one sessions that meet regularly to help them recover or rehabilitate. Peer Mentoring provides individuals who have suffered from a specific life experience the chance to learn from those who have recovered, or rehabilitated, following such an experience. Peer Mentors provide education and support opportunities to individuals. The Peer Mentor may challenge the Mentee with new ideas, and encourage the Mentee to move beyond the things that are most comfortable.

Peer support and mentoring services for both children and adults would consist of but not be limited to:

- Assistance with navigating the health care delivery system and eliminating barriers to care
- Performing care coordination activities
- Accessing community-based support services and serving as a patient advocate and linking Medicaid recipients to medical resources, .
- Assistance with making appropriate and safe health care utilizations choices.
- Assistance with the improving the individual's self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community.
- For individuals transitioning from an institution or residential setting, subsequent to a prolonged stay, would also receive assistance in acclimating and adapting to community living.
- Provide necessary supports and services to children with current or prior involvement with the child welfare or juvenile justice system who are at risk for hospitalization or residential treatment.

Waiver Authority Sought
This request seeks to modify paragraph 26 of the current STCs to stipulate that Peer Supports and Peer Mentoring services are available to any qualified Medicaid beneficiary irrespective of

their delivery system enrollment. Access to these services will be based on an assessment of need.

Rationale
This provides community-based care solutions for Medicaid recipients with medical, behavioral, functional, and social needs to promote less invasive and lower cost interventions. With intimate knowledge of available community resources, the Peer Support/Mentor will link members with a multitude of resources in order to assist them in overcoming barriers to appropriate Medical and community based services use; assist members to be responsible, accountable, and self-sufficient health care consumers; and serve as their mentor and coach to achieve positive health and wellness outcomes.

Waiver Request Item #6: In-Home Behavioral Health Programs

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

Waiver Authority Sought
The state is seeking authority to provide the benefits outlined above to Medicaid recipients.

Rationale
Providing these services will prevent future health care expenditures on emergency room and residential treatment services in more costly settings. In addition, these treatment modalities can stabilize chronic behavioral health conditions and increase the child's ability to function and thrive in their family and community. This treatment can also delay the need for full Medicaid eligibility and institutionalization.

Waiver Request #7 Item: Habilitative Services

The State of Rhode Island requests to remove habilitation services from requiring a Hospital Level of Care. Those individuals requiring habilitation activities will be eligible to receive those services with a Highest or High Level of Care.

Rationale
The population that would benefit from Habilitative services does not always meet the Hospital Level of Care as defined in the current 1115 Waiver. Expanding the eligibility for these services

will facilitate a greater number of Medicaid beneficiaries to live in the community and receive the scope of services most appropriate to their needs.

Waiver Authority Sought
The state is seeking authority to provide the benefits outlined above and to amend Attachment B of the current 1115 STCs

Waiver Request Item #8: Housing Stabilization Services

Housing Stabilization Services help people to live as independently as possible in the community. Services can either be provided in the home, or within specific accommodations like sheltered housing or a hostel for homeless people. Housing Stabilization Services provide a range of different tasks to help someone manage their home, such as assistance to claim public benefits, fill-in forms, manage a household budget, keeping safe and secure, getting help from other specialist services, obtain furniture and furnishings, and help with shopping and housework. The type of support that is provided will aim to meet the specific needs of an individual person.

Housing Stabilization Services are to be targeted to subpopulations who are currently Medicaid eligible or at risk of becoming Medicaid eligible. By providing home-based supportive housing services to highly vulnerable individuals and families, the state hopes to realize reductions in costly medical interventions and improvement in overall health. These interventions will not only allow clients to achieve housing stability, but will improve their health outcomes, reducing their cost to Medicaid.

Through the provision of Housing Stabilization Services, eligible clients will receive supportive housing and community services. Services like home based case management, substance abuse counseling, medication management, financial counseling, and life skills training will help empower clients, improve independent living skills and their overall quality of life.

Once in housing, ongoing supports can be provided to clients to help prevent future housing crisis's and ensure thoughtful management of their ongoing care (like ensuring clients take their prescriptions and follow-up with physician appointments).

Over time, these services will improve client employment opportunities and stability, and thus their reliance on publicly funded health care, for adults who are able to work.

EOHHS will work in collaboration with the Office of Housing and Community Development, Department of Human Services, and Department of Behavioral Health, Developmental Disabilities, and Hospitals for the design and provision of Housing Stabilization Services.

Waiver Authority Sought
EOHHS seeks a waiver of Section 1902(a)(10)(B), amount, duration, and scope in order to offer alternative services to only certain individuals identified, and to offer these services in the most cost-effective setting, e.g. a person's residence.

The State of Rhode Island requests the authority under Section 1115 to obtain federal matching funds for expenditures for the housing stabilization services provided to Medicaid-eligible adults in the target population.

Additionally, the state seeks the authority to provide Housing Stabilization Services to adults with income up to 200% of the FPL who are at risk for Medicaid eligibility and require these housing stabilization services based on functional and/or clinical limitations.

Rationale

National Research has demonstrated that Housing Stabilization Services and other supportive housing services are a cost-effective intervention to improve health outcomes. In Denver, a study found 50% of tenants placed into supportive housing experienced improved health status, 43% had improved mental health outcomes, and 15% reduced substance use (Perlman and Parvensky, 2006). Results from a Massachusetts statewide pilot found that Medicaid costs pre and one-year post supportive housing decreased 67% in mean Medicaid costs ($26,124 to $8,499). It is the state's expectation that waiver of comparability to provide Housing Stabilization Services will result in similar health improvements and savings in line with national trends.

Furthermore, the support of Housing Stabilization Services under Medicaid will help the Rhode Island Interagency Council of Homelessness (modeled after the Federal Interagency Council on Homelessness) continue its work on preventing and ending homelessness.

According to a 2012 study done by Providence College, over 38% of the persons utilizing the homeless shelter system in Rhode Island from 2010 – 2012 were recipients of Medicaid, with a total cost of $58,136,486. The top 67 chronically homeless clients on this list represented $9,325,375 of those costs, with an average $4,971 per person per month.

Providing access to these supportive services will prevent future health care expenditures on emergency room and hospitalization for addiction-related illnesses, as well as prevent expenses on treatment in higher cost settings (e.g. residential substance abuse treatment). This request also aligns with our guiding principle of ensuring Medicaid-financed services are responsive and appropriate to a person's medical, functional and social needs.

Population/Eligibility Group

Housing Stabilization Services would be available to the following groups:

- Medicaid-eligible children and families.
- Medicaid-eligible adults with community medical assistance and/or long-term care eligibility, including elders.
- Non-Medicaid eligible adults with an income up to 200% FPL

Housing Stabilization Services shall be targeted to persons in the groups listed above who meet one or more of the following criteria:

- Are "doubled up" or at risk of losing their housing;
- Are fleeing domestic violence and/or staying in Domestic Violence Safe Home; or

- Reside in a homeless shelter or transitional housing facility;
- Require long-term restorative interventions and support to maintain stable housing

The state expects these populations will include persons who are living in institutional settings, exiting correctional systems, and/or transitioning from youth to adult services. Historically these populations are frequent users of high-cost emergency or hospital care, but could improve their health outcomes through Housing Stabilization Services.

Benefits

EOHHS is requesting a waiver of comparability and expenditure authority in order to provide a set of Housing Stabilization Services to be delivered in a home-like setting. These services will be individualized based on client needs and include health care coordination (including mental health and substance use), assistance navigating benefit systems, and intensive case management (to help triage acute issues and maintain housing).

Housing Stabilization Services are considered a "wrap-around" benefit to the traditional Medicaid-covered services. Other examples include, but are not limited to:

- Service coordination (including mental health and substance use),
- Medication management/monitoring,
- Entitlement assistance/ benefits counseling,
- Tenancy supports,
- Independent living skills training,
- Job skills training/education,
- Domestic violence intervention,
- Support group/self-determination/life satisfaction,
- Individual counseling, reengagement, &
- Discharge planning.

The Individuals up to 200% of federal poverty level who are not currently eligible for Medicaid will only qualify for the Housing Stabilization Services and not all Medicaid covered benefits.

The full set of benefits will be developed in collaboration with the Office of Housing and Community Development, Department of Human Services, and Department of Behavioral Health, Developmental Disabilities, and Hospitals.

Waiver Request Item #9: Healthy Works Initiative

The Healthy Works Initiative is designed to provide a package of work -related services and supports to adults. The Healthy Works Initiative is premised on evidence-based research showing that people with steady "meaningful" jobs are healthier contributing members of society. As a recent CMCS Informational Bulletin makes the point, "Works is a fundamental part of adult life for people *with and without* disabilities...*Meaningful* work has also been associated

with positive physical and mental health benefits and is a part of building a healthy lifestyle as a contributing member of society."[5]

Moreover, steady employment continues to be the primary source of commercial health coverage for adults and, as such, is one of the most effective ways of containing Medicaid enrollment and costs.

Although it is not clear which comes first – stable employment or good health – the Healthy Works Initiative will focus narrowly on the relationship between work and health from both sides: health issues that are an obstacle to stable employment will be assessed and addressed as will employment problems that adversely affect health. "Meaningful" work, as defined for the purposes of this initiative, is a job in which participants not only have access to the health and work services and supports they need, but they must also earn at least the minimum wage.

There are two components to the Initiative, Healthy Works I and Healthy Works II, each of which focuses on the employment needs of people "with and without disabilities" who are Medicaid eligible, at risk for Medicaid eligibility, and/or potential users of high cost interventions or long term care. As such, the Healthy Works Initiative also provides an important opportunity for the state to demonstrate the efficacy of one of the principles of this Waiver extension: employment and housing stabilization play a crucial role in optimizing health and reducing/delaying Medicaid eligibility and/or the need for high cost services.

Healthy Works I

Healthy Works I targets adults up to age 64 who are eligible for Medicaid on the basis of a disability (i.e., including individuals receiving SSI or determined by the State to have a disability or who are eligible for Medicaid-funded long-term care) as well as people between 27 and 64 with income up to 200% of the FPL who are: (1) income eligible for Medicaid or at risk for becoming Medicaid eligible; and (2) diagnosed with a chronic illness or condition. Healthy Works I will use the authority available under Sections 1915(c)(5)(C) and 1915(i) of the SSA, to provide a set of expanded supported employment, prevocational and habilitative services that build on or fill in the gaps in the existing menu of supports available to members of the target population under section 110 of the Rehabilitation Act (1973), the applicable provisions of the Individuals with Disabilities Education Act (IDEA), and the Medicaid rehabilitation option.

In Rhode Island, Medicaid-funded employment support efforts for persons with disabilities are typically rehabilitative (i.e., services that address capacity issues but that do not have steady work as an explicit outcome). Healthy Works I is designed to augment these efforts. For example, Healthy Works I complements the state's "employment first" policy now being pursued by other agencies under the Executive Office of Health and Human Services (EOHHS) umbrella. The policy was advanced for people with disabilities by the RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) and is an important component of reforms implemented recently in the system of care for the people the agency services. Thus, the goal of Healthy Works I is to further efforts to make integrated community-based employment a central component of the individualized service plan of Medicaid eligible

[5] Emphasis added.

people with disabilities receiving services in the home- and community-based setting. In keeping with this goal, the state has been mindful of the technical guidance provided in the CMCS Informational Bulletin of September 16, 2011, outlining the scope and limits of Medicaid-funded employment and employment supports for people with disabilities.[6]

Healthy Works II

Healthy Works II is a pilot which focuses on low income unemployed or underemployed adults at a critical transition stage in life: young adults ages 18 to 30. The pilot is distinct from Healthy Works I, and most other state Medicaid employment initiatives, in two important ways: first, the state is seeking to make employment services available to adults in the target population irrespective of health status (i.e., no disability, chronic condition or illness required). Healthy Works I, like most other state Medicaid-funded employment initiatives, is reserved for people with or at risk for a disability of some kind. Second, the package of services offered to participants in the pilot will include 1915(c) waiver and 1915 (i) State Plan supported employment, prevocational, and habilitative services as well as a set of employment rewards that promote job placement, training, and retention. The employment rewards are to be made available initially only through the Healthy Works pilot.

The pilot component of the initiative is limited in scope and size to allow the efficacy of a rewards driven system to be tested while assisting young adults, a population shown to have a high level of need. This target group was selected for the pilot as a result of studies revealing that 18-30 year olds are less likely than their more mature counterparts to have access to the employment services and supports they need to obtain and retain a steady job.[7] This same research indicates that young adults are vulnerable to undiagnosed/untreated health illnesses with the potential to affect their ability to find and keep both a job and continuing health coverage, especially for conditions that are not recognized as disabilities in the adult world. Moreover, there is compelling evidence that the health status of unemployed and underemployed young adults who are not enrolled in higher education or vocational institutions is well below that of their counterparts.[8]

The expansion of Medicaid coverage to young adults gives the State—which currently has the highest unemployment rate in the nation—the chance to provide the full set of integrated services, medical and social, essential for improving their job status and overall health. The pilot will be limited to 200 participants per year.

Core Services and Supports

The Healthy Works Initiative will include the following:

[6] CMCS Informational Bulletin. Center for Medicaid, CHIP and Survey & Certification (CMCS). *Updates to the §1915 (c) Waiver Instructions and Technical Guide Regarding Employment and Employment Related Services*. Available at: http://www.ct.gov/dds/lib/dds/community/employment_informational_bulletin.pdf

[7] Pamela Loprest and Elaine Maag. *Disabilities Among TANF Recipients: Evidence from the the NHIS.* The Urban Institute. Available at: http://www.urban.org/UploadedPDF/411883_disabilitiesamongtanf.pdf

[8] Ibid. Note: Underemployed for the purposes of the pilot means pay per hour for a week's work averages below the minimum wage, working less than 30 hours week.

Case Management – identification of a persons' needs, the development of a plan to address those needs, assistance with accessing the required services, and ongoing support to ensure that the plan is being implemented and is addressing the identified needs.

Career Planning and Placement
Providing assistance to develop realistic career goals and working with participants to identify employment sites that will help to achieve career goals.

Customized Employment Services
An extensive planning phase in which the participants work with case managers to identify their goals, desires, and employment needs. This information is then used to guide their employment searches and negotiate individualized employment relationships with employers.

Service Coordination
The case manager collaborates with others providing support and, to extent required, ensure all the necessary workplace and personal services are in place for sustained, successful employment.

Prevocational Supports – assist participants in acquiring the skills required to thrive in the workplace.

Attendance
Teach the importance of being present regularly at a place of employment and coordinating efforts to maintain employment.

Motor Skills
Assist in the development of movements that combine to produce a smooth, efficient action in order to master a particular task.

Workplace Safety
Help participants to understand the policies and procedures that are in place to ensure the safety and health of employees within a workplace. This involves hazard identification and ongoing safety training and education for employees.

Interview Skills
Providing participants with the skills to talk to people in an interview situation, answer questions, and understand the right questions to ask a potential employer.

Job Search Assistance
Activities that support and assist each participant in searching for an appropriate job that complements their individual skills, minimizes their limitations, and advances toward their career goals.

Job (skill) Training
Training that improves a participant's ability to do their work—but not a specific task—in a timely, successful manner by focusing on developing the major skills used daily at work (e.g., organizing and managing materials, focusing on specific tasks).

Transportation
Provide access to and from work through transportation services.

Health Maintenance and Social Engagement—helping people to maintain their health and engage in positive social interactions in the workplace to ensure overall wellness and wellbeing.

Targeted Health/Behavioral Health Services
Peer supports and/or navigation to guide and reinforce healthy behaviors and engage coworkers.

Learning Disability Management
Process to prevent a disability from becoming more complex by having an individual fully understand the nature of the disability and what supports will be needed in order to go about day to day employment activities

Personal Assistance Services
Providing caregiver supports to individuals with limitations that prevent them from performing basic functions of everyday life. These services can be provided in a place of employment.

Work Rewards—employer and participant rewards to encourage hiring, training, and retention as well as work milestones. For the Healthy Works II pilot, these rewards may take the form of bonuses for participants who stay on the job for a set period of time or cash rewards for employers who offer other core employment services/supports, jobs with higher wages, etc. The state proposes to use the flexibility and authority under this Section 1115 demonstration to include rewards that do not typically qualify for federal financial participation under Section 1915(c) waiver or Section 1915 (i) State Plan employment services (e.g., indirect subsidies). The state intends to establish a roundtable of business leaders and health experts to assist in identifying appropriate participant and employer rewards for the pilot. As well, the state will seek federal guidance in developing more fully this core service options for the Healthy Works II pilot.

Eligibility and Service Planning
The focus of the Healthy Works Initiative is people in the target populations who are Medicaid eligible or at risk for becoming Medicaid eligible under any of the following:

Healthy Works I **Adults with Disabilities** **Ages/Income as Indicated**	**Healthy Works II** **Ages 18 to 30** **Up to 200% FPL**
Medicaid Institutional or Prevent Level of Need or Preventive Level of Need ages 19 to 64	Chafee Independence Program Beneficiaries
Rhody Health, Rhody Health Options, Connect Care Choice or ACA, Eligible with a diagnosed disability -- ages 30 to 64	ACA, Rhody Health, Rhody Health Options, or Connect Care Choice Eligible

RI Works Parents/Caretaker Relatives with a diagnosed disability >30	RI Works Parents/Caretaker Relatives
SSI Eligible, or Application Pending or Denied	SSI Application pending or denied

Both components of the Healthy Works Initiative] will be coordinated with, but not be a substitute or duplicative of ongoing complementary programs administered through the State's TANF program—RI Works, the Office of Rehabilitative Services, the Department of Behavioral Healthcare Developmental Disabilities and Hospitals, the Department of Labor and Training, and other agencies to the extent appropriate and feasible. An individual plan of services will be developed for each participant in the initiative tailored to meet his or her unique needs. If a participant in either component of Healthy Works already has an employment plan developed through another publicly funded agency, the onus will be on the case manager to integrate Health Works services and supports into that plan rather than develop a new or additional one. Although the state expects these individual plans to include a different array of health and employment supports, the desired outcome is the same: a stable job and good health. The state will develop a variety of measures to determine whether and to what extent this outcome has been achieved and which core services/support played a critical role.

Healthy Works Roundtable

To assist in developing work rewards and arrangements with employers interested in joining the Initiative, the Secretary of EOHHS plans to convene a Healthy Works Roundtable, consisting of health experts and industry leaders and representatives. The Roundtable will play a crucial role in identifying the skills and supports essential for obtaining and retaining meaningful work in the target populations. Additionally, the Roundtable will recruit employers to participate in the Initiative and advise the Secretary on appropriate employer rewards. Last, the Secretary will also rely on the Roundtable to provide direction and advice on the evaluating the success of the initiative and possible expansion of the pilot.

Waiver Authority Requested

The State proposes to use the full range of habilitative services available under the Section 1915 (i) State Plan option as well as a unique set of incentives and rewards for worker hiring, training and retention through the State's Section 1115 waiver demonstration.

Amount, duration and scope: Waiver of section 1902(a)(10)(B) as implemented in Code of Federal Regulations, chapter 42, 440.240(b) to authorize the State to: (1) offer employment support benefits that vary from benefits available under the State Plan to Initiative participants; and, (2) to establish limits on enrollment and/or maintain waiting lists for supports and services for Medicaid eligible participants the Healthy Works II pilot.

Costs Not Otherwise Matchable (Budget Population 23)

The State of Rhode Island requests the authority under Section 1115 to obtain federal matching funds for employment supports and work rewards not available under a Section 1915(c) waiver

or Section 1915(i) State Plan option to participants in the Healthy Works II pilot. Additionally, the state seeks the authority to include in adults with income from 133% to 200% in the target populations.

Rationale

The experience of the states and empirical research provide compelling evidence of the strong relationship between employment stability and good health. Aside from the benefits from income and, in many instances, access to employer sponsored health insurance, steady work is correlated with an array of positive outcomes including moderating or delaying the onset of chronic diseases, promoting overall wellness, and reducing risky behaviors such as smoking, substance abuse, and obesity related conditions. As a result, people with stable employment are not only often healthier overall, but also less likely to need high cost treatments, interventions and institutionally based services until much later in life if ever. For example, research has consistently shown that TANF participants with an unaddressed health condition "have a significantly lower likelihood of employment."[9]

With the amendments to Section 1915 (i) under the ACA, states have had the option to expand employment initiatives under their Medicaid State Plans to people with disabilities who do not have an institutional level of need. The state's goal in the Healthy Works Initiative is to seek the authority in this Section 1115 waiver to pursue the employment initiatives allowed under both Section 1915(c) and Section 1915(i) for the target population of people with disabilities. From the state's perspective, stable, meaningful employment is essential for both rebalancing the long term care system and implementing Rhode Island's integrated care initiative. The Medicaid expansion to low income adults under the ACA affords Rhode Island the opportunity to extend Medicaid funded work supports a step further. The flexibility and authority available through a Section 1115 demonstration will enable the state to provide a wider range of employment supports to a small group of young adults without regard to health status.

Impact of Change

The benefits of the Healthy Works Initiative are multiple and far reaching. The state's long-term goal is to ensure that Rhode Islanders retain their independence and health for as long as possible. Today, Medicaid plays an important role in supporting efforts to promote to successful community living for persons with disabilities. Employment for persons with disabilities is important for an individual's self-worth, connection to the community, and income growth. Healthy Works I will assure that people with disabilities will have access to the supports necessary to obtain steady work thereby decreasing reliance on more costly services. By providing additional employment supports, there is an increased opportunity for eligible people to not only attain employment, but also to become vital members of the state's economy. Healthy Works II will offer us the opportunity to evaluate whether steady work can assist young adults transition into the workforce and, in doing so, improve health outcomes and shift or divert people from Medicaid and other publicly funded health coverage to private, employer sponsored insurance. Additionally, the more people at work the greater the benefit to the state's economy and overall growth.

[9] Pamela Loprest and Elaine Maag. *Disabilities Among TANF Recipients: Evidence from the the NHIS.* The Urban Institute. Available at: http://www.urban.org/UploadedPDF/411883_disabilitiesamongtanf.pdf

Waiver Request Item #10: Revision to Attachment C, Recategorization of Family Planning Codes to Family Planning Service Categories

In an effort to reduce administrative complexity the state is seeking to modify how family planning codes are defined. In renewing this Demonstration, the state looks to alter the definition of family planning services from procedure codes to procedure code categories. All other aspects of the Extent of Federal Financial Participation for the Extended Family Planning Program as outlined in Paragraph 84 in the prior extension remain in effect.

The code categories to replace Attachment C, of the current STCs, are as follows:

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

<u>Waiver Authority Sought</u>
The state requests the authority to change Family Planning Codes in Attachment C of the current STCs to Family Planning Code Categories. As procedure codes are added to categories described above, these codes are automatically considered family planning services.

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

Other Waiver Element

This change reduces the administrative burden of keeping the definition of family planning services up to date.

The specified preventive services are those assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF), and approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP).

A list of the services that are eligible for the increased FMAP can be found on the following websites:
http://www.uspreventiveservicestaskforce.org/uspstf/topicsprog.htm
http://www.cdc.gov/vaccines/schedules/hcp/adult.html

SECTION IV. COST SHARING REQUIREMENTS

The State will no longer seek to utilize co-pays in its cost sharing plan with the exception of EFP.

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

Please refer to Attachment D for a description of cost-sharing authority.

SECTION V. DELIVERY SYSTEM AND PAYMENT RATES FOR SERVICES

Section V provides an overview of the delivery system Rhode Island proposes for providing benefits both to Demonstration participants and to Medicaid beneficiaries more generally. Although Demonstration participants constitute the large majority of Medicaid beneficiaries, beginning January 1, 2014, Rhode Island intends to expand Medicaid eligibility to include adults without dependent children with incomes up to 133% of FPL. Note that legislative approval for this expansion is pending. Eligibility for this expansion population will be pursued through state plan authority and is not part of this extension proposal. Rhode Island does, however, intend to enroll this new population group in managed care on a mandatory basis.

For people currently eligible only for Medicaid, Rhode Island employs both managed care and primary care case management (PCCM) systems. Rhode Island oversees the operation of a series of successful programs which have been nationally recognized for their quality, including RIte Care, RIte Share, Rhody Health Partners, Connect Care Choice, RIte Smiles and the Program of All-Inclusive Care for the Elderly (PACE). These programs will be continued in the extension period.

For children and families, enrollment in RIte Care is mandatory with choice between one of two participating MCOs (Neighborhood Health Plan of Rhode Island or United Health of New England). Children with special health care needs are also enrolled in RIte Care with a choice of plans. Children in substitute care arrangements are enrolled in RIte Care by voluntary action of the Rhode Island Department of Children, Youth, and Families (DCYF) in its role as guardian. For dental benefits, children born on or after May 1, 2000 are enrolled in our managed dental program, RIte Smiles. Medicaid-only adults with disabilities are enrolled in either our managed care program, Rhody Health Partners or in our PCCM program, Connect Care Choice. Enrollment in RIte Care and Rhody Health Partners is limited to those persons who do not have access to other insurance coverage such as employer-sponsored insurance (ESI) or Medicare. RIte Share, our ESI premium assistance program is available when enrollment in ESI is more cost effective than enrollment in RIte Care or Rhody Health Partners. Rhode Island's PACE program with an enrollment of approximately 250 people is operated in collaboration with CMS.

Through these programs, Rhode Island Medicaid delivers services through the following arrangements:

- Managed care
  - ✓ Managed Care Organization (MCO)
  - ✓ Prepaid Ambulatory Health Plans (PAHP)
- Fee-for-service
  - ✓ Primary Care Case Management (PCCM)
  - ✓ Health Homes
- Other (please describe)
  - ✓ Program of All-Inclusive Care for the Elderly (PACE)

The following table summarizes these arrangements.

Eligibility Type	Delivery System
Families with Dependent Children	Enrolled in RIte Care with one of two participating MCOs for medical care RIte Smiles PAHP for dental benefits, if born on or after May 1, 2000
Women who receive Extended Family Planning Benefits	Enrolled in one of two participating MCOs
Children with Special Health Care Needs	Enrolled in RIte Care with one of two participating MCOs FFS for children with other comprehensive insurance coverage RIte Smiles PAHP for dental benefits, if born on or after May 1, 2000
Children in Substitute Care Arrangements Youth aged out of foster care system eligible under the Affordable Care Act	Enrolled in RIte Care with MCO selected by the Department of Children, Youth, and Families RIte Smiles PAHP for dental benefits, if born on or after May 1, 2000
Families with Dependent Children who have access to employer-sponsored insurance	Enrolled in RIte Share program. Commercial carrier is primary, and Medicaid fee-for-service wraps around that benefit
Aged, Blind, and Disabled (ABD) Adults – Medicaid Only	Enrolled in: • Rhody Health Partners with one of two MCOs • Connect Care Choice • PACE • FFS for persons with other comprehensive insurance coverage
Aged, Blind, Disabled (ABD) Adults – Medicare and Medicaid Eligible (MME)	To be Enrolled in: • Rhody Health Options with one of two MCOs • Connect Care Choice Community Partners • PACE
Childless Adults eligible under the Affordable Care Act	To be enrolled in participating managed care organizations

The scope of benefits in our managed care contracts does not include all Medicaid benefits. Covered benefits primarily include acute, primary, and specialty care services. Long-term care services and supports (LTSS) remain within our fee-for-service environment, along with dental care for those persons not currently eligible for Rite Smiles and certain intensive behavioral health services and special services for medically complex cases. For home- and community-based LTSS, the current Demonstration has afforded the state the ability to move away from discrete, capped enrollments and provided greater flexibility to make community-based services available to Medicaid enrollees to better enable them to continue to live successfully in a community setting.

Going forward, Rhode Island seeks to build on its successful experience in serving Medicaid beneficiaries through capitated managed care (RIte Care and Rhody Health Partners) and primary care case management (Connect Care Choice) programs.

We have recently submitted to CMS a category change to implement our Integrated Care Initiative. This Initiative is described in Attachment F. Although we are pursuing approval of the Integrated Care Initiative as a category II change to the existing waiver, we include the description of the program in this waiver extension request because it is a significant change. Under the Integrated Care Initiative, we will establish two new programs. These are the managed care-based Rhody Health Options program and an enhanced PCCM program, Connect Care Choice Community Partners. These programs will extend our managed care and PCCM programs to include dual-eligible beneficiaries (or MMEs). We will also make the scope of covered benefits in managed care more comprehensive—to include long-term care services as well as home- and community-based services—and with a clear focus on preventing avoidable emergency room visits and hospitalizations while advancing our efforts to enable more people to successfully reside in the community. This is consistent with our belief that the effectiveness of our managed care programs can be enhanced by including the full range of Medicaid services. This approach aligns with our requests for expedited eligibility for LTSS and for waiver authority for an expanded scope of benefits. Furthermore, this conforms with our guiding principle of ensuring Medicaid-financed services are responsive and appropriate to a person's medical, functional, and social needs.

Beyond the Integrated Care Initiative, we see opportunities to strengthen our managed care operations and our methods of health care delivery to conform to the principles guiding this waiver extension request. Over time, managed care models have evolved, taking on populations with increasingly complex medical and behavioral health needs. The most successful models are those with active engagement and partnerships with providers, families, and communities. Particularly for our most vulnerable populations we are seeking integrated medical, behavioral health, and social models of care that incorporate high touch, person-centered care focusing on an individual's strengths and natural supports while addressing health needs. We can further strengthen our primary care infrastructure through our support for patient-centered medical homes. By developing new payment models, we can recognize and incentivize quality and health outcomes through coordination and integration with other publicly financed health care. Aligning with other insurance systems will increase coordination and reward promising approaches to care. We can also engage with communities and providers to build more

accountable systems. Therefore, in addition to seeking authority for expanding managed care, EOHHS requests authority to proceed with initiatives to improve delivery systems and modify payment arrangements.

In pursuing these system improvements, Rhode Island seeks additional authority for the following initiatives.

Delivery System Waiver Request Item #1: Mandatory enrollment in managed care for the Medicaid Expansion group – Adults without dependent children

Description of Change:

In extending Medicaid coverage to adults without dependent children, Rhode Island will be adding an eligibility group to its Medicaid program. In keeping with our commitment to managed care as our preferred delivery system, EOHHS will enroll these adults in managed care.

Waiver Authority Sought
RI currently has the authority to waive freedom of choice for individuals in the Demonstration (paragraph 37 of the STCs). The Medicaid expansion population is not included in the Demonstration's eligibility groups; rather they will be added through state plan authority. Rhode Island seeks to extend the freedom of choice waiver to include the Medicaid expansion group.

Delivery System Waiver Request Item #2: Dental Services for Older Children and Adults

Description of Change:

The state implemented RIte Smiles, its managed dental care benefit for Medicaid/CHIP children, in September 2006. The RIte Smiles Program currently serves Rhode Island children born on or after May 1 2000. This program has been successful in increasing access to dental services, promoting development of good oral health behaviors, decreasing the need for emergency and restorative dental care, and decreasing Medicaid expenditures for oral health.

Waiver Authority Sought
The waiver currently provides authority to limit freedom of choice of providers for individuals in the Demonstration. Rhode Island does not currently exercise this authority for mandatory managed care enrollment for the delivery of oral health care for those born before May 1, 2000. Oral health care for older children and adults remains within the fee-for-service system. Through this waiver, the state seeks the authority to establish mandatory managed care enrollment for these populations.

Delivery System Request Item #3: Amendment to Institute of Mental Disease (IMD) Exclusion

Description of Change:

Access to effective treatment for substance use disorders is an important tool for optimizing the health of people who are at high risk for institutional care. One of the principal factors affecting the availability of these services in Rhode Island is the application of the Medicaid Institution of Mental Disease (IMD) rule to certain high-quality residential treatment programs. As defined in section 1905(i) of the Social Security Act and 42 CFR 435.1009, IMDs are inpatient facilities of more than 16 beds that have patient rosters of people with severe mental illness of more than 51%. Federal financial participation is not available for services provided to people between the ages of 22 and 64 even if they are otherwise Medicaid eligible. This initiative proposes to waive the IMD rule, or its impact, for certain persons who have substance use disorders and are participating in residential treatment programs with a census of 16 or more beds.

Waiver Authority Sought

- Waiver of IMD exclusion as defined in section 1905(i) of the Social Security Act and 42 CFR 435.1009 thereby allowing Medicaid coverage and federal financial participation for fee for services residential substance abuse treatment for otherwise Medicaid-eligible people.
- Amount, duration and scope in section 1902(a)(8) of the Social Security Act and 42 CFR 440.2409B0 to the extent necessary to allow the State to vary services to people within the eligibility group based on the availability of residential substance abuse treatment beds.

Rationale

The IMD rule was crafted at a time when state governments across the nation maintained institutions for people with mental illnesses and bore full financial and administrative responsibility for their operations. Whatever the original intent, the rule imposes considerable constraints on the ongoing efforts of states to pursue initiatives to achieve mental health parity and implement integrated care models. The goals of the Affordable Care Act, and Medicaid expansions authorized by the law, also raise questions about the IMD rule's continuing applicability.

The rule's impact has been particularly pronounced in Rhode Island. It has limited access to substance abuse treatment programs for fee-for-service participants and also constrained the Medicaid-funded services and supports required for people to make successful transitions back to the community. Those programs are evidence-based and clinically effective components of an integrated system of services designed to promote overall health rather than just treat single conditions, diseases, or disorders.

Impact of Change

The proposed change will have an immediate impact on otherwise Medicaid-eligible adults, ages 22 to 64, in fee for service who have a clinical need for residential substance abuse treatment and the services and supports required to make the transition to back into the community.

In Rhode Island, there are five residential providers in six different locations statewide. During state fiscal year 2012, approximately 1300 people were served by these providers, with 1500 total stays. Of the 1500 stays, approximately 400 stays were for Medicaid-eligible beneficiaries.

To remain viable, most of these programs have more than 16 beds. As such they are defined as IMDs. Consequently, federal financial participation is not available for the services they provide through Medicaid fee-for-service programs for people who would be eligible for Medicaid if the same services were provided in a smaller – i.e., less than 16 bed – setting. The application of the IMD exclusion not only makes it difficult to serve all the Medicaid-eligible people who need residential abuse treatment, but also undermines efforts to ensure continuity of care for those who are served.

Delivery System Waiver Request Item #4: Delivery System Reform Incentive Payments

Description of Change:

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

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

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

achieving improvements in health, healthcare and costs; and reward community providers for engaging with hospitals to achieve this goal. The RI DSRIP will test a model for addressing these misaligned incentives.

Program Description

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

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

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

- Reducing preventable Emergency Department visits, hospitalizations, and re-hospitalizations.
- Addressing population health issues (such as diabetes, hypertension, and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, and leveraging aligned federal and state programs.
- Deploying cross-provider care teams to improve care and reduce preventable or unnecessarily-costly utilization by “super-utilizers”.
- Integrating primary care and behavioral health.
- Ensuring appropriate care is delivered in appropriate settings.
- Improving perinatal and maternity care.
- Improving primary care for all populations through increased adoption of the Patient-Centered Medical Home model of care.

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

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

Incentive Payment Structure

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

Infrastructure costs for development will be provided to the System with DSRIP funds in Years 1-2, but must be matched by non-state funded infrastructure investments by the System.

Calculation of incentive payments will be based on achievement of mutually agreed upon targets for quality, utilization, and member satisfaction. Distribution of incentive payments among System providers will be proposed by the System and approved by the state and CMS.

Waiver Authority Sought

The state requests federal matching funds for state general revenue payments to hospitals.

1902(a)(10) – The state requests a waiver to enable it to provide non-Medicaid State Plan Services to the population.

1902(a)(1) - The state requests a waiver of the state wideness requirements set forth in the section to permit it to offer different types of services in different geographic regions of the state.

The DSRIP will incentivize the system to invest in services that best suit a person's needs, by providing incentives based on quality, appropriate utilization, and member satisfaction. Capitalizing on the waiver authority requested elsewhere in this extension request to deploy peer navigators, peer mentors, and intensive case management, the DSRIP will be able to provide a more person-centered approach to high quality, appropriate utilization.

By including measures of behavioral health, care coordination, and appropriate care for children in state custody, DSRIP will require currently "siloed" elements of the delivery system to work in collaboration to achieve the required performance goals.

Timeline of Initiative:

Demonstration Year 1	• Identification of designated Pilot System • Identification of quality, patient experience, access, and cost measures • Baseline data collection • Development and approval by state and CMS of incentive structure

	• Agreement on investments and milestones for achieving infrastructure payments
Demonstration Year 2	• Year 1 data collection for quality, patient experience, access, and cost measures • Implementation of agreements for incentive payments among System providers • Distribution of infrastructure investments with DSRIP funds for milestones achieved
Demonstration Years 3-5	• Infrastructure investments completed • Quarterly monitoring of quality, patient experience, access, and cost measures • Distribution of DSRIP incentives to System for achievement of benchmarks

Rhode Island is fully committed to monitoring the impacts of the Demonstration on quality, cost, access to care, and health status of its covered populations by using the methodologies that have been outlined in the state's *Proposed Evaluation Design for Section 1115 Waiver No. 11-W-00242/*1, its revised *Quality Strategy for Managed Care Services*, and its quarterly *Designated Medicaid Information* report to the Rhode Island General Assembly's Senate Committee on Health and Human Services. In addition, the state's proposed Integrated Care Initiative has significant focus on quality measurement, to promote the delivery of coordinated, high quality, cost effective services for Medicare/Medicaid enrollees.

Delivery System Waiver Request Item #5: Community Health Team

Description of Change:

EOHHS requests Demonstration authority to pilot a new structure for the delivery of community-based supports for Medicaid beneficiaries, aimed at optimizing appropriate utilization of the health care system and improving beneficiary health. The pilot Community Health Team (CHT) will be responsible for providing a broad array of services and supports to Medicaid recipients within a defined geographic area, served by a defined network of primary care medical homes.

CHT services may include those services covered and not covered by the current state plan. CHTs will have flexibility in the determination of services to be provided. At a minimum, CHTs will make available Peer Navigators and/or Community Health Workers who will assist the members in understanding their medical conditions and appropriately accessing healthcare services (see also "Benefits"). Other services that may be provided through the CHT include coordination with behavioral health, health education, nutritional counseling, access to transportation, and housing stabilization services. The array of services provided by the CHT will be determined by a qualitative and quantitative understanding of the needs of the community of beneficiaries to be served.

Rationale

Community support services are a critical component of a coordinated and person-centered delivery system. Particularly for Medicaid beneficiaries faced with social, behavioral, and economic barriers to good health, appropriate and effective use of the health care system can be significantly improved by the integration of non-medical support services into the delivery system. Yet easy access to such services remains a challenge for Medicaid beneficiaries, and no structure exists to ensure adequate distribution and availability of such services throughout a community with high needs. The CHT provides such a structure.

Program Description

One region of the state with a high penetration of Medicaid beneficiaries, high prevalence of behavioral health diagnoses, and high hospital and ED utilization, will be selected for a pilot Community Health Team. An organization to provide CHT services will be selected by a competitive bidding process.

Primary care practices which provide services to Medicaid beneficiaries in the geographic area of the CHT will be identified. Medicaid recipients will be attributed to the CHT based on their receipt of care from affiliated primary care provider groups. The CHT will receive a per member per month payment (PMPM), either from the MCO or through FFS, to provide an array of services based on the assessed needs of the population, with the goal of reducing the need for emergency department, hospital and nursing home care, and improving the health outcomes of their attributed members.

The CHT will be responsible for ensuring communication with primary care practices. The governance structure of the CHT must include members of the community who are Medicaid recipients, primary care providers, emergency department staff, behavioral health organizations, and community-based organizations such as religious institutions, educational institutions or other relevant local agencies.

Measures of the effectiveness of the CHT will be similar to those for the Delivery System Reform Incentive Payment pilot, described above. These measures include:

- Reducing preventable Emergency Department visits, hospitalizations, and re-hospitalizations.
- Addressing population health issues (such as diabetes, hypertension, and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, and leveraging aligned federal and state programs.
- Deploying cross-provider care teams to improve care and reduce preventable or unnecessarily-costly utilization by “super-utilizers.”
- Integrating primary care and behavioral health.
- Ensuring appropriate care is delivered in appropriate settings.
- Improving perinatal and maternity care.

Payment Structure

Payments to the CHT will be based on a capitated PMPM rate. Members will be determined by attribution to an affiliated primary care site within the "catchment area" of the CHT.

Services provided by primary care medical homes within the catchment area will not be duplicated within the community health team. Instead, the community health team will serve as an adjunct to the medical home, providing those services which are not provided or paid for through payments to the medical home.

In the first year of the Demonstration, payments to the CHT will be made for the full amount of the capitated PMPM fee. Services will be developed and implemented, Medicaid members will receive education about the availability of community health services, and relationships with primary care providers, community agencies, hospitals, and behavioral health providers will be established. Milestones for each of these implementation steps will be developed and agreed upon by the Medicaid program. Baseline performance measures on the above quality metrics will be established during this year as well.

In the second year of the program, quality and utilization metrics for the population served by the CHT will be reported and fed back to the team and affiliated providers. PMPM payments will continue.

In the third through fifth years of the demonstration, quality measurement and reporting will continue. The PMPM payment will decrease, and a portion of the payment will be held back as a "quality withhold" until the completion of the contract year. The team will have the opportunity to earn back some or all of the quality withhold dollars if mutually agreed upon quality and utilization metrics are achieved.

Waiver Authority Sought

1902(a)(10) – The state requests a waiver to enable it to provide non-Medicaid State Plan services to the population.

1902(a)(1) - The state requests a waiver of the state wideness requirements set forth in the section to permit it to offer different types of services in different geographic regions of the state.

SECTION VI. DEMONSTRATION FINANCING

This section addresses potential questions regarding Demonstration Financing.

Will all non-federal share of Demonstration Expenditures be financed with State general funds?

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

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

Can Rhode Island confirm that providers retain 100% of the payments for services rendered or coverage provided?

Yes – Providers receive and retain 100% of the payments for services rendered; providers receive and retain 100% of the total Medicaid expenditures claimed by the state.

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

No – Providers do not participate in any intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments.

The Non-Federal Share (NFS) for each type of Medicaid payment is funded through state general fund revenues.

Does the NFS come from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS? Are there state appropriations for NFS made to state agencies aside from those to the Medicaid agency?

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

For State Fiscal Year 2013, what is the estimate of total expenditures and NFS amounts for each type of Medicaid payment?

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

Does the state agency receive any of its NFS through a matching arrangement with a local government entity using ICTs or CPEs?

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

There are no contributions to NFS from local government agencies (e.g. counties, local municipalities). Note that expenditures related to Local Education Authorities (LEAs) are not included in the Waiver. Appropriations for other state agencies are shown below:

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

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

The state makes supplemental payments to hospitals based on the difference between actual Medicaid payments and an estimated outpatient Upper Payment Limit (UPL). The methodology for determining this UPL is described in the response below.

Provider Type	**Period**
Non-government hospitals – Outpatient Hospital UPL Payment	7/1/2011 – 6/30/2012: $12,109,748 7/1/2012 – 6/30/2013: $11,764,752 (est.)
DSH (not included in waiver)	7/1/2012 – 6/30/2013: $127,715,725(est.)

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

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

The one state-owned hospital (Eleanor Slater Hospital) is operated and managed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). The

hospital's Medicare allowable costs, as contained in the Medicare Cost Report, is the basis for determining interim and final Medicaid payments. This cost-based payment methodology ensures that Medicaid payments for this class of provider do not exceed the Upper Payment Limit (UPL).

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

The state employs the following methodology to estimate UPL for privately owned and/or operated nursing facilities.

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

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

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

No - In the case of MCOs or, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

No - Capitation rates are certified as actuarially sound in compliance with 42 CFR 438.6(c) and the CMS Rate Setting Checklist.

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

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

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

Does Rhode Island seek enhanced FMAP for any of its program initiatives?

Financing Waiver Request Item: Expand Enhanced FMAP for Health Homes past 8 quarters

Description of Change:

In November 2011, Rhode Island received approval from CMS for two Health Home State Plan Amendments. Community Mental Health Organizations serving clients with Severe and Persistent Mental Illness (SPMI) are one such designated Health Home. CEDARR Family Centers are the second Health Home and serve children and youth with special health care needs.

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

Waiver Authority Sought
Rhode Island is requesting expenditure authority under section 1115 (a)(2) in order to receive enhanced FMAP for Rhode Island's two Health Homes through September 30, 2015.

Rationale
Expansion of the Health Home program aligns with the following two waiver goals:

- Ensure information about services and how to access them is readily available and consistent.
- Ensure Medicaid financed services are responsive and appropriate to a person's medical, functional and social needs

In addition, eight quarters is an insufficient amount of time to evaluate the effectiveness of the Health Home program.

SECTION VII. BUDGET NEUTRALITY

In the current Waiver period the state is subject to an aggregate cap of 12.075 billion, beyond which no federal financial participation is available. In this extension, Rhode Island seeks to remove the hard cap of $12.075 billion and approach budget neutrality in a more traditional manner.

We propose to modify the existing budget neutrality agreement through the addition of the next five-year extension period. The budget neutrality agreement we propose will be composed of the $12.075 billion from the initial period plus the additional projected without waiver expenditures for the five year extension period.

In projecting the without waiver expenditures for the proposed extension period, our starting point is the estimated expenditure amount for Demonstration Year 5 as set forth in paragraph 92 of the STCs, "Enforcement of Budget Neutrality". This is $2.375 billion or the difference between Demonstration Years 4 and 5 in the cumulative target. This is then used as the base year in developing without waiver estimates for Demonstration Year 6 through Demonstration year 10. The basis for these projections is set forth below.

This Budget Neutrality section also provides "with waiver" estimates for the extension period. These projections are based on five years of historical experience trended forward for Demonstration Years 6 – 10. In this section these estimates are developed using the base year of SFY 2007 and the five year period from SFY 2008 -2012.

For both without waiver and with waiver forecasts, estimates will be impacted by the implementation of the ACA. Inherent uncertainties regarding future enrollment, costs and utilization for the extension period pose unique challenges. While the Governor's budget reflects an expansion of Medicaid to adults without dependent children to 138% FPL, we have not included this population in these estimates. We propose to exclude costs associated with this population from the budget neutrality agreement.

A. Background to Budget Neutrality Forecasts

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

Table 7.1: Waiver Timing

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

The initial waiver period is not yet complete. For the with waiver forecast, historical data based on date of service and including claims completion is available through the end of SFY 2012 (June 30, 2012). Accordingly, the analysis in this section includes a "bridge" period during

which costs are forecast through to the end of the initial five year period. This year five then serves as the basis for with waiver forecasts into the extension period. The bridge period is consistent across all populations and services, and captures the final 18 months of the current waiver period.

Table 7.2: Waiver Timing: Bridge Period

	Historical Data	Bridge Period	Waiver Period
Beginning Date	July 1, 2006	July 1, 2012	January 1, 2014
Ending Date	June 30, 2012	December 31, 2013	December 31, 2018
Including	SFY 2007-SFY 2012	SFY 2013 thru CY 2013	CY 2014-2018

B. Expenditures Subject to Budget Neutrality

Paragraph 76 of the STCs sets forth the agreement that expenditures subject to budget neutrality means all medical assistance payments except for DSH, phase down Part D contributions and LEA payments for the initial waiver period. These medical assistance payments constitute all expenditures for Demonstration Populations and Demonstration Services as described in paragraph 75 of the STCs[10].

These Demonstration Populations and Demonstration Services for the initial waiver period are shown in Table 7.3.

Table 7.3: Current Expenditures Subject to Budget Neutrality

Budget Populations	Budget Population 1	ABD no TPL
	Budget Population 2	ABD TPL
	Budget Population 3	RIte Care
	Budget Population 4	CSHCNs
	Budget Population 5	EFP
	Budget Population 6	Pregnant Expansion
	Budget Population 7	SCHIP Children
	Budget Population 8	CNOM: Substitute Care
	Budget Population 9	CNOM: CSHCNs otherwise in voluntary state custody
	Budget Population 10	CNOM: 65, <200%, at risk for LTC
	Budget Population 11	217-like, CatNeedy HCBW like svcs, Highest Need
	Budget Population 12	217-like CatNeedy HCBW like svcs, High need
	Budget Population 13	217-like Medically Needy, HCBW like svcs (high and highest). Medically Needy P ACE-like participants in community
	Budget Population 14	BCCTP
	Budget Population 15	CNOM: Adults w/ disabilities at risk for LTC, <300% FPL
	Budget Population 16	CNOM: Uninsured Adults w/ mental illness

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

	Budget Population 17	CNOM: Youth at risk for Medicaid; at risk children < 300% FPL
	Budget Population 18	HIV
	Budget Population 19	CNOM: Non-working disabled adults 19-64, GPA
Budget Services	Budget Services 1	Windows
	Budget Services 2	RIte Share and collections
	Budget Service 3	Other payments - e.g.FQHC suppl., stop loss
	Budget Services 4	CNOM: core and preventive svcs, Medicaid eligible at risk youth
	Budget Services 5	CNOM: Services by FQHCs to uninsured individuals

All related expenditures shown in Table 4 are reported in accordance with the CMS 64 reporting instructions.

C. Budget Neutrality Summary: RI Forecasts, With & Without Waiver

In this extension, Rhode Island seeks to build on its financial accomplishments to date and to move its programs forward into this new era of reform. As such, the state has developed forecasted expenditure estimates for the full ten-year waiver period. These forecasts are presented below. Expenditures are based on all federally matched Medicaid services, as described in section B.

Table 7.4 provides Rhode Island's estimated total forecasted expenditures without the waiver, for the ten-year waiver period (CY 2009-18). The without waiver expenditures for the initial five-year period is $12,075 Million. The aggregate ten-year without waiver expenditure under the extension is $27,244 Million, which is composed of the $12,075 Million from the initial period plus the additional $15,169 Million for the five-year extension period.

Table 7.4: Without Waiver Forecast/Budget Neutrality Cap Summary (WOW)

Trend		Historical CY						Base Yr CY	Waiver Period CY				
		2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
				DY 1	DY 2	DY 3	DY 4	DY 5	DY 6	DY 7	DY 8	DY 9	DY 10
Expenses $ Millions													
Total	7.4%			2,600	2,400	2,300	2,400	2,375	2,601	2,831	3,035	3,241	3,462
								Year over year projected total expense trend:	*9.5%*	*8.8%*	*7.2%*	*6.8%*	*6.8%*
Enrollment													
Total	2.2%							196,948	204,613	213,639	217,662	220,396	223,167
PMPM													
Total	5.1%							1,005	1,059	1,104	1,162	1,225	1,293

Waiver Cap Years 1-10	**DY 1-10**	**CY 2009-18**	**27,244**
Waiver Cap Years 6-10	**DY 6-10**	**CY 2014-18**	**15,169**

Rhode Island's estimated without waiver forecast is based on an enrollment trend of 2.2% and a cost trend of 5.1% per annum. This cap is based on national Medicaid PMPM trend and historical Rhode Island eligibles trend, adjusted for non-recurring anticipated events over the proposed renewal period as described in section D below.

Once a without waiver target is established, budget neutrality requires that the state develop an

anticipated "with waiver" baseline forecast. Table 7.5 provides with waiver expenditure projections for the ten-year waiver period (CY 2009-18).

The historical and projected expenditure for the initial five-year period is $8,813 Million. The aggregate ten-year projected expenditure under the extension is $20,872 Million, which is composed of the $8,813 Million from the initial period plus the additional $12,059 Million for the five-year extension period, as shown below.

Table 7.5: With Waiver Forecast Summary (WW)

	2014-2018	Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Expenses $ Millions													
Total*	**6.6%**	1,421	1,534	1,595	1,730	1,784	1,773	**1,932**	2,103	2,270	2,414	2,559	2,713
ABD	5.0%	971	1,027	1,092	1,139	1,161	1,138	1,222	1,301	1,372	1,440	1,509	1,582
C+F	9.0%	450	507	503	591	622	635	711	801	897	974	1,050	1,131
							Year over year projected total expense trend:		8.8%	8.0%	6.4%	6.0%	6.0%
Enrollment													
Total	**2.3%**	180,662	176,760	175,179	182,977	189,131	193,030	**197,322**	205,275	214,597	218,925	221,972	225,065
ABD	1.9%	45,652	45,328	45,748	46,576	47,429	48,329	**49,581**	50,693	51,889	52,839	53,736	54,649
C+F	2.5%	135,011	131,432	129,431	136,402	141,702	144,701	**147,741**	154,582	162,709	166,086	168,236	170,416
PMPM													
Total	**4.2%**	655	723	759	788	786	765	**816**	854	881	919	961	1,004
ABD	3.1%	1,773	1,888	1,989	2,038	2,040	1,963	**2,053**	2,139	2,204	2,271	2,341	2,412
C+F	6.4%	278	322	324	361	366	365	**401**	432	460	489	520	553

Waiver Fcst Years 1-10	**DY 1-10**	**CY 2009-18**	**20,872**
Waiver Fcst Years 6-10	**DY 6-10**	**CY 2014-18**	**12,059**

Rhode Island's with waiver forecast is based on an enrollment trend of 2.3% and a cost trend of 4.2% per annum. In accordance with CMS guidance, these trends are based on five years of historical experience, including a base year of SFY 2007 and the five year period from SFY 2008-12, projected forward through the extension period, adjusting for non-recurring historical and anticipated events as described in section E.

Note that Rhode Island's estimated with waiver forecast for the ten-year waiver period (CY 2009-18) shown in Table 7.5 is $6,372 Million less than the ten-year without waiver estimate shown in Table 7.4 above. This difference captures the estimated reduction in cost associated with the Waiver. As demonstrated by this difference, the Waiver (both in its current form and the proposed extension) allows both the State and the Federal Government to control rising Medicaid expenditures, thereby providing the basis for the fiscal solvency and sustainability of the Medicaid program in Rhode Island.

D. Methodology used in developing Rhode Island's Without Waiver Forecast

The without waiver forecast was developed through the following two-step process: First, develop a baseline. And second, adjust this baseline for non-recurring anticipated events not included in the baseline. This process is outlined below.

Step D1: Develop a baseline -- Current Waiver Period Without Waiver Estimates
As shown in Table 7.6, the budget neutrality cap for the initial five-year period is $12.075 billion. This cap reflects the combined state and federal determination, at the outset of the Waiver, for what would have happened absent the Waiver over the initial five-year period. As such, in projecting the without waiver forecast for the proposed extension period, Rhode Island's starting point is the current budget neutrality cap, and specifically the estimated expenditure amount for Demonstration Year 5, $2,375M.

Note that Table 7.6 also compares the annual targets to the actual expenditures under the waiver to date as reported in the CMS-64 report.[11] As shown below, Rhode Island's experience during the initial period of this waiver has been positive, with total expenditures to date estimated at $7, 241 Million, well below the projected without waiver target of $9,700 Million.

Table 7.6: Budget Neutrality To Date (Initial Waiver Period)[12,13]

$ Millions	CY 2009 DY1	CY 2010 DY2	CY 2011 DY3	CY 2012 DY4	CY 2013 DY5	CY 2009-2012 DY 1-4	CY 2009-2013 DY 1-5
Target	$2,600	$2,400	$2,300	$2,400	$2,375	$9,700	$12,075
Budget Neutrality Spend	$1,757	$1,862	$1,841	$1,781	NA	$7,241	NA
Difference	($843)	($538)	($459)	($619)		**($2,459)**	

In creating the without waiver forecast, the budget neutrality targets to date (described above) are trended forward based on national Medicaid PMPM cost trend projections and Rhode Island specific enrollment expenditure trends. The baseline projected without waiver expenditures over the waiver period are shown in Table 7.7 below.

Table 7.7: Baseline Projected WOW Expenditures *(prior to adjustments)*

		Historical CY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
				DY 1	DY 2	DY 3	DY 4	DY 5	DY 6	DY 7	DY 8	DY 9	DY 10
Expenses $ Millions													
Total	6.8%			2,600	2,400	2,300	2,400	2,375	2,537	2,709	2,894	3,091	3,301
								Year over year projected total expense trend:	*6.8%*	*6.8%*	*6.8%*	*6.8%*	*6.8%*
Enrollment													
Total	1.3%							196,948	199,575	202,237	204,934	207,668	210,438
PMPM													
Total	5.4%							1,005	1,059	1,116	1,177	1,240	1,307

As indicated in the table, the baseline projected without waiver expense trend is 6.8%, which incorporates a 1.3% enrollment trend and a 5.4% PMPM trend.
For Table 7.7 note that:

[11] After adjustments for the exclusion of LEA, SCHIP and DSH related expenditures. Source: 9-30-12 Global Waiver Budget Neutrality Report: Rhode Island Global Consumer Choice Compact 11 W-00242/1 Section 1115 Demonstration
[12] Note that DY 4 includes 1/1/12 – 9/30/12. For further detail see RI EOHHS website , "Quarterly Operation Report Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration July 1, 2012 – September 30, 2012"
[13] Source: 2009-2012 Expenditures_CMS64_2013-02-07, Net of DSH, LEA, & SCHIP

- Available Medicaid national PMPM projections over the renewal period (CY2014-18) are based on "with ACA population assumptions", which are NOT included in RI's waiver renewal. As such, this forecast builds on a national Medicaid PMPM trend of 5.4% between CY2011-13[14].
- Details on Rhode Island's forecasted eligibles trend is provided in Section F of this document.

Step D2: Adjustments to Baseline Without Waiver Projections

The without waiver forecast is then adjusted for non-recurring anticipated events over the proposed renewal period that were not included in the baseline – that is, events that would not have been appropriately captured in the national Medicaid PMPM trend between 2011-13 and/or the Rhode Island historical enrollment trend.

Table 7.8: Projected WOW Expenditures/budget neutrality cap *(after adjustments)*

		Historical CY						Base Yr CY	Waiver Period CY				
Trend		2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
				DY 1	DY 2	DY 3	DY 4	DY 5	DY 6	DY 7	DY 8	DY 9	DY 10
Expenses $ Millions													
Total	**7.4%**			2,600	2,400	2,300	2,400	2,375	2,601	2,831	3,035	3,241	3,462
							Year over year projected total expense trend:		*9.5%*	*8.8%*	*7.2%*	*6.8%*	*6.8%*
Enrollment													
Total	**2.2%**							196,948	204,613	213,639	217,662	220,396	223,167
PMPM													
Total	**5.1%**							1,005	1,059	1,104	1,162	1,225	1,293

Waiver Cap Years 1-10	**DY 1-10**	**CY 2009-18**	**27,244**
Waiver Cap Years 6-10	**DY 6-10**	**CY 2014-18**	**15,169**

For this table, note the following adjustments:

- The ACA requires that Medicaid payment rates for some categories of primary care spending increase to equal Medicare rates for a two year period. RI Medicaid anticipates that this increase will likely continue throughout the waiver period, in order to achieve targeted access standards and retain qualified providers.
- Projections have been adjusted to reflect the anticipated impact of the 2% tax imposed on for profit insurers and nonprofits with less than 80% Medicaid enrollees, beginning in CY 2014 under the ACA. It is estimated that 11% of projected ABD spending and 24% of Child and Family spending will be subject to this tax.
- In accordance with the ACA, beginning in 2014, Rhode Island will implement new streamlined eligibility systems and processes, coupled with substantial community outreach and education intended to encourage all Rhode Islanders to access coverage. Enrollment projections have therefore been adjusted to reflect the anticipated increased take-up of currently eligible but not enrolled Rhode Islanders. Additional details on this adjustment are provided in Section F of this document.

Taken together, these adjustments are projected to raise the average annual enrollment trend from the historical rate of 1.3% to 2.2% and decrease the average annual PMPM trend from

[14] CMS: 2011 Actuarial Report on the Financial Outlook for Medicaid, table 3, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2011.pdf

5.4% to 5.1%.

E. Methodology used in developing Rhode Island's With Waiver Forecast

Similar to the without waiver estimates described in Section D, the with waiver forecast was developed through the following two-step process: First, develop a baseline. And second, adjust this baseline for non-recurring events over the historical and proposed waiver period. This process is outlined below.

Step E1: Develop a baseline – Five Year Historical Experience

The with waiver forecast begins with an assessment of five years of historical experience, including a base year of SFY 2007 and the five year period from SFY 2008-12.

As indicated in the Table 7.9, the baseline historical expense trend for Rhode Island Medicaid was 1.8%, which incorporates a 1.3% enrollment trend and a 0.5% PMPM trend. In step 1, the baseline with waiver forecast simply projects this historical experience forward, without any adjustments, as shown below.

Table 7.9: Baseline Projected With Waiver Expenditures *(prior to adjustments)*

		Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Expenses $ Millions													
Total	**1.8%**	1,621	1,692	1,696	1,785	1,802	1,773	**1,822**	1,856	1,890	1,926	1,962	1,999
ABD	2.6%	1,002	1,046	1,103	1,151	1,166	1,138	**1,183**	1,213	1,244	1,277	1,310	1,343
C+F	0.5%	619	645	592	634	636	635	**639**	642	646	649	652	655
Enrollment													
Total	**1.3%**	180,662	176,760	175,179	182,977	189,131	193,030	**196,904**	199,529	202,191	204,887	207,621	210,390
ABD	1.1%	45,652	45,328	45,748	46,576	47,429	48,329	**49,162**	49,726	50,296	50,872	51,456	52,045
C+F	1.4%	135,011	131,432	129,431	136,402	141,702	144,701	**147,741**	149,804	151,895	154,015	156,165	158,345
PMPM													
Total	**0.5%**	748	798	807	813	794	765	**771**	775	779	783	787	792
ABD	1.4%	1,829	1,924	2,010	2,059	2,049	1,963	**2,005**	2,033	2,062	2,091	2,121	2,151
C+F	-0.9%	382	409	381	388	374	365	**361**	357	354	351	348	345

For this baseline projection note that:

- Enrollment and cost trends were analyzed within two subpopulations: ABD adults and Children and Families.
- This report is based on a five year historical Rhode Island Medicaid claims extract that includes claims, capitation payments, premiums and provider payouts and reflects data based on date of service with an estimate for IBNR (incurred but not reported) for claims paid through November 2012. Capitations, premiums and payouts are allocated to Medicaid coverage groups, service types and care setting based on respective claims and payout information with IBNR.

Step E2: Adjustments to With Waiver Baseline Projections

The with waiver forecast is then adjusted for non-recurring anticipated events over the historical and proposed waiver period. Overall after adjustments, the with waiver forecasts

$12,059 Million in Medicaid expenditures over the extension period. This is based on an average annual enrollment trend of 2.3% and an average annual PMPM trend of 4.2%, as shown in the table below.

Table 7.10: Projected WW Expenditures *(after adjustments)*

	2014-2018	Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Expenses $ Millions													
Total*	**6.6%**	1,421	1,534	1,595	1,730	1,784	1,773	**1,932**	2,103	2,270	2,414	2,559	2,713
ABD	5.0%	971	1,027	1,092	1,139	1,161	1,138	1,222	1,301	1,372	1,440	1,509	1,582
C+F	9.0%	450	507	503	591	622	635	711	801	897	974	1,050	1,131
							Year over year projected total expense trend:		8.8%	8.0%	6.4%	6.0%	6.0%
Enrollment													
Total	**2.3%**	180,662	176,760	175,179	182,977	189,131	193,030	**197,322**	205,275	214,597	218,925	221,972	225,065
ABD	1.9%	45,652	45,328	45,748	46,576	47,429	48,329	**49,581**	50,693	51,889	52,839	53,736	54,649
C+F	2.5%	135,011	131,432	129,431	136,402	141,702	144,701	**147,741**	154,582	162,709	166,086	168,236	170,416
PMPM													
Total	**4.2%**	655	723	759	788	786	765	**816**	854	881	919	961	1,004
ABD	3.1%	1,773	1,888	1,989	2,038	2,040	1,963	**2,053**	2,139	2,204	2,271	2,341	2,412
C+F	6.4%	278	322	324	361	366	365	**401**	432	460	489	520	553

Waiver Fcst Years 1-10	**DY 1-10**	**CY 2009-18**	**20,872**
Waiver Fcst Years 6-10	**DY 6-10**	**CY 2014-18**	**12,059**

For this forecast note that:

- Experience has been adjusted to reflect the one-time reduction in pharmacy costs, beginning in SFY 2010, due to the application of the lowest payer rules for Medicaid pharmacy costs to managed care plans under the Drug Rebate Equalization Act (DRE). This savings should continue annually throughout the waiver period – however, the one time reduction associated with the implementation of this program must be excluded from trend.
- Experience has been adjusted for the restructuring of benefits and costs associated with children in foster care. Between SFY 2008 and SFY 2011, the number of children residing in residential settings has been sharply reduced as children have been transitioned to community settings.
- Experience has been adjusted for the one-time cost reduction associated with the 2009 transition of child intensive services (CIS) to an in plan benefit.
- Experience has been adjusted for the 2009 implementation of the Generic First program, whereby enrollees are now required to purchase generic drugs, if available, for all appropriate diagnoses. This program is intended to continue through the waiver renewal; however, the one time reduction associated with the transition to this new program will NOT reoccur.
- Experience has been adjusted for the January, 2011 implementation of reductions in hospital inpatient payment rates in managed care to 90.1% of June 2010 payment rates and contained inpatient and outpatient hospital payment rate increases to CMS market basket trend rates. This program is intended to continue through the waiver renewal; however, the one time reduction associated with the transition to this new program will not reoccur.
- During the initial waiver period, Rhode Island experienced a substantial economic

decline, at some points reporting the highest unemployment rates in the country. During this poor economic climate, birth rates declined to unusually low levels. With the improvement in the Rhode Island economy, it is anticipated that this birth rate is likely to increase. We have therefore conservatively adjusted trends to hold birth rates constant over the renewal period by increasing the birth rate in SFY 2007 to 2011 levels, thereby negating the impact of the decline in births on trend.

- Rhode Island has actively pursued strategies to transition some nursing home populations to more appropriate settings. It is a priority for Rhode Island to continue to transition people out of nursing homes and into more cost effective and appropriate settings; however, we do not anticipate that the rate of decline will continue at the historical levels. The initial decline associated with this transition (2007-2009) is therefore excluded from trend, allowing for a more moderate decline as experienced in recent years.
- After all previous adjustments were made to the historical data, PMPM rates still decrease in some recent subpopulations and years. It is common actuarial practice to smooth out any negative trends from historical data when projecting forward, under the assumption that any reduction year over year is likely a data or time limited anomaly. [15] SFY 2012 PMPM is therefore calculated by using the four year average trend from SFY2008-12 as the increase from 2011 to 2012.
- The enrollment trend in ABD adults 65+ is adjusted to reflect an aging population, allowing for a constant share of a growing over 65 population of Rhode Islanders during the waiver renewal, and the anticipated increase in asset spend down for this age group as a result of the recent economic downturn and the depletion of assets as a result of reduced values of homes and stock market declines. Even with the recent growth of stock values, for many seniors that growth is on a much reduced base.
- The ACA requires that Medicaid payment rates for some categories of primary care spending increase to equal Medicare rates for a two year period. We anticipate that this increase will likely continue throughout the waiver period, in order to achieve targeted access standards and retain qualified providers.
- Projections have been adjusted to reflect the anticipated impact of the 2% tax imposed on for profit insurers and nonprofits with less than 80% Medicaid enrollees, beginning in CY 2014 under the ACA. It is estimated that 11% of projected ABD spending and 24% of C+F spending will be subject to this tax.
- In accordance with the ACA, beginning in 2014, Rhode Island will implement new streamlined eligibility systems and processes, coupled with substantial community outreach and education intended to encourage all Rhode Islanders to access coverage. Enrollment projections have therefore been adjusted to reflect the anticipated increased take-up of currently eligible but not enrolled Rhode Islanders. Additional details on this adjustment are provided in Section F of this document.

[15] CMS Financial Review Rates Checklist 7/22/03. Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Rate setting. Item AA5.2.

F. Methodology used in developing Rhode Island's Enrollment Forecast

There are inherent uncertainties in projecting Medicaid enrollment over the extension period, as these projections are substantially impacted by the ACA, and the resulting population behaviors, coverage rates, and health status are difficult to predict. Nonetheless, such projections are an integral part of the waiver extension, and described below.

Step F1: Baseline Enrollment Projections

Both the with waiver and without waiver forecasts are based on the same starting point: historical Rhode Island Medicaid enrollment by population subcategory. As shown below, Rhode Island's baseline enrollment projection includes SFY 2012 average eligibles of 193,030, projected forward at a historical trend rate of 1.3%.

Table 7.11: Baseline Projected Medicaid Enrollment *(prior to Aging Adjustment, ACA impacts)*

	2014-2018	Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Enrollment													
Total	1.3%	180,662	176,760	175,179	182,977	189,131	193,030	196,904	199,529	202,191	204,887	207,621	210,390
ABD	1.1%	45,652	45,328	45,748	46,576	47,429	48,329	49,162	49,726	50,296	50,872	51,456	52,045
C+F	1.4%	135,011	131,432	129,431	136,402	141,702	144,701	147,741	149,804	151,895	154,015	156,165	158,345

For this baseline projection note the following:

- Enrollment trends were analyzed within two subpopulations: ABD adults and Children and Families.
- This report is based on a five year historical Rhode Island Medicaid claims extract that includes claims, capitation payments, premiums and provider payouts and reflects data based on date of service with an estimate for IBNR (incurred but not reported) for claims paid through November 2012. Capitations, premiums and payouts are allocated to Medicaid coverage groups, service types and care setting based on respective claims and payout information with IBNR.

Step F2: Aging Adjustment

According to census projections, the share of Rhode Islanders 65+ is increasing over the waiver period. As such, Rhode Island has adjusted the baseline enrollment trend in ABD adults 65+ to reflect a constant share of a growing over 65 population of Rhode Islanders during the waiver renewal, and the anticipated increase in asset spend down for this age group as a result of the economic downturn and the depletion of assets as a result of reduced values of homes and stock market declines.

The adjusted enrollment forecast over the waiver period is shown below. This adjustment increases the forecasted ABD enrollment trend from 1.1% to 1.7%, resulting in an overall enrollment trend of 1.5%.

Table 7.12: Projected Medicaid Enrollment *(After Aging Adjustment, Prior to ACA impacts)*

Projected Enrollment after Aging Adjustment													
Total	1.5%	180,662	176,760	175,179	182,977	189,131	193,030	197,322	200,237	203,195	206,197	209,244	212,337
ABD	1.7%	45,652	45,328	45,748	46,576	47,429	48,329	49,581	50,433	51,300	52,182	53,079	53,992
C+F	1.4%	135,011	131,432	129,431	136,402	141,702	144,701	147,741	149,804	151,895	154,015	156,165	158,345
increase in ABD		-	-	-	-	-	-	*418*	*707*	*1,004*	*1,310*	*1,623*	*1,946*

Step F3: ACA Increase in Take up of Eligible but not Enrolled Rhode Islanders
Once the baseline was established, and the aging population was incorporated, step 3 was to estimate the impact of the implementation of the Affordable Care Act on enrollment.

In accordance with the ACA, beginning in 2014, Rhode Island will implement new streamlined eligibility systems and processes, coupled with substantial community outreach and education intended to encourage all Rhode Islanders to access coverage. The table below summarizes the adjusted enrollment forecast over the waiver period, incorporating the increased take-up of currently eligible but not enrolled Rhode Islanders.

Table 7.13: Projected Medicaid Enrollment *(After Aging ACA Adjustments)*

Projected Increased Enrollment								SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Enrollment starting 7/1/2014								-	10,076	12,728	12,728	12,728
Translate to CY								CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
CY 2014 = half of SFY 2014								5,038	11,402	12,728	12,728	12,728
CY 2015 = average of SFY 2014/15, CY 2016-18 = full rampup												
Projected Enrollment after Aging Adjustment												
	2014-2018	Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total	1.5%	180,662	176,760	175,179	182,977	189,131	193,030	197,322	200,237	203,195	206,197	209,244	212,337
annual trend									*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*
Projected Enrollment after Eligible but Unenrolled Increase													
	2014-2018	Historical SFY						Base Yr CY	Waiver Period CY				
	Trend	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total	2.3%	180,662	176,760	175,179	182,977	189,131	193,030	197,322	205,275	214,597	218,925	221,972	225,065
ABD	1.9%	45,652	45,328	45,748	46,576	47,429	48,329	49,581	50,693	51,889	52,839	53,736	54,649
C+F	2.5%	135,011	131,432	129,431	136,402	141,702	144,701	147,741	154,582	162,709	166,086	168,236	170,416
increase in enrollment		-	-	-	-	-	-	-	*5,038*	*11,402*	*12,728*	*12,728*	*12,728*
annual enrollment trend									*4.0%*	*4.5%*	*2.0%*	*1.4%*	*1.4%*

Rhode Island's increased take up estimates for currently eligible but not enrolled Rhode Islanders as a result of the ACA implementation incorporate the following set of assumptions:

+ **Rhode Island Population Estimates**
  Rhode Island population estimates, with breakdowns for uninsured and privately insured Rhode Islanders by income category, were based on the Census Bureau's American Community Survey (ACS) 2011 data. According to ACS, there are 116,220 uninsured Rhode Islanders and 619,465 privately insured Rhode Islanders under 65 years of age, as shown below:

Breakdown of RI Population:		
Uninsured <65	116,220	11%
Medicaid/RIteShare	191,435	18%
Privately Insured <65	619,465	59%
Over 65 (Non-Medicaid)	124,182	12%
Total RI Population	**1,051,302**	**100%**

Source: ACS 2011

+ **Medicaid Eligible Populations**
  Once population estimates were established, the share of each subpopulation that was income eligible for Medicaid was identified. Note that undocumented Rhode Islanders were excluded from these estimates, based on estimates from Jon Gruber, MIT. Also note that while it is anticipated that Rhode Island will extend coverage to adults without dependent children pursuant to provisions of ACA, this population is not included in the waiver proposal and budget.

+ **Increased Take up of Medicaid Eligible Populations**
  Once Medicaid eligible populations were established, the likely increase in take up of eligible but not enrolled populations was estimated. For budgeting purposes, Rhode Island estimates that 33.6% of Medicaid eligible uninsured Rhode Islanders will enroll, post 2014. And an additional 14.4% of Medicaid eligible privately insured Rhode Islanders are also anticipated to enroll, post 2014, as shown below:

Table 7.14: Increased Take up of Medicaid Eligible Populations

	Total Uninsured	Total Private Insured <65	Total Uninsured & Private
Currently Income-Eligible for Medicaid (1)	18,431	57,939	76,370
Newly Eligible for Medicaid under ACA (2)	48,144	67,364	115,508
Ineligible for Medicaid	49,645	494,162	543,807
Total Population	**116,220**	**619,465**	**735,685**
Calculate Expected Enrollment			
Currently Income-Eligible for Medicaid	18,431	57,939	76,370
Less estimated undocumented (3)	5,381	Not estimated	
Remaining Eligible Population	**13,050**	**57,939**	**70,989**
Takeup Rate (4)	33.6%	14.4%	
Expected Enrollment	**4,385**	**8,343**	**12,728**

(1) Parents <133% FPL, Children <250% FPL
(2) Childless adults <133% FPL
(3) Estimates from Jon Gruber, MIT
(4) Estimates from Jon Gruber, plus 20% per Medicaid modified forecast

- **Ramp Up**
  Increased enrollment from the eligible not enrolled population is estimated to start in July 2014 and ramp up to the total 12,728 expected additional eligibles by July 2016, as shown below:

Table 7.14: Ramp up Assumptions

Projected Increased Enrollment	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Enrollment starting 7/1/2014	-	10,076	12,728	12,728	12,728
Translate to CY	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**
CY 2014 = half of SFY 2014	5,038	11,402	12,728	12,728	12,728
CY 2015 = average of SFY 2014/15, CY 2016-18 = full rampup					

SECTION VIII: CURRENT & PROPOSED WAIVERS & EXPENDITURE AUTHORITY

WAIVER LIST

Title XIX Waivers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. **Payment for Self-Directed Care** **Section 1902(a) (32)**

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

8. Payment Review **Section 1902(a)(37)(B)**

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

9. Out-Stationing Waiver

The State seeks a waiver of 42 USC 1396 a (a) 55-CFR-435.904, as described in Section 2 of this 1115 Demonstration Renewal.

EXPENDITURE AUTHORITY

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

The following expenditure authority shall enable Rhode Island to operate its 1115 Demonstration Renewal.

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

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

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

community based services, are not otherwise eligible under the approved State Plan, whom are found to be in the highest and high need group, and whose income and resources are within the level to qualify for eligibility under the standard for institutionalized individuals.

5. Expenditures for medical assistance for the following populations:
    a. **Budget Population 8** [*substitute care*]: Children and families in managed care (children under 19 & parents). Parents pursuing behavioral health treatment with children temporarily in State custody with income up to 200 percent of the FPL.
    b. **Budget Population 9** [*Children with special health care needs Alt.*]: CSHCN (as an eligibility factor) who are 21 and under who would otherwise be placed in voluntary State custody up to 300 percent of the SSI.
    c. **Budget Population 10** [Elders 65 and over]: At risk for LTC with income at or below 250 percent of the FPL who are in need of home and community-based services (state only group).
    d. **Budget Population 11**: 217-like Categorically Needy Individuals receiving HCBW-like services & PACE-like participants highest need group.
    e. **Budget Population 12**: 217-Like Categorically needy individuals receiving HCBW like services and PACE like participants in the High need group
    f. **Budget Population 13**: 217 Like Medically needy receiving HCBW like services in the community (high and highest group). Medically needy PACE-like participants in the community
    g. **Budget Population 14**: [BCCTP] Women screened for breast or cervical cancer under CDC program and not eligible for Medicaid.
    h. **Budget Population 15 [Adults with disabilities at risk for long-term care]:** HCBS waiver like services for adults living with disabilities with incomes at or below 300 percent of the SSI with income and resource lists above the Medicaid limits.
    i. **Budget Population 16 [Uninsured adults with mental illness]:** Services for uninsured adults with mental illness and or substance abuse problems with incomes below 200 percent of the FPL not eligible for Medicaid and adults with mental illness and substance abuse problems with incomes below 200 percent of the FPL who live in families (a) in which a child is at risk for out-of-home placement and into the protective custody of the Department of Children, Youth and Families (DCYF) or (b) in which a child has already been removed from the home and reunification efforts are occurring.
    j. **Budget Population 17 [Youth at risk for Medicaid]:** Coverage of detection and intervention services for children under age 18 who have special health care needs not eligible for Medicaid up to 300 percent of the SSI. Expenditures are inclusive of children under age 18 who have a special health care need; e.g. Seriously Emotionally Disturbed (SED), behavioral challenges and/or medically dependent conditions, who may be safely maintained at home with appropriate intensive levels of care, including specialized respite services.
    k. **Budget Population 18 [HIV]:** Persons living with HIV with incomes below 200 percent of the FPL who are ineligible for Medicaid.
    l. **Budget Population 19 [Non-working disabled adults]:** Non-working disabled adults ages 19-64 who do not qualify for disability benefits.
    m. **Budget Population 20 – Adults 19-64 with Alzheimer's disease or Related Dementia:** Expenditures for adults aged 19-64 who have been diagnosed with

Alzheimer's Disease or a related Dementia as determined by a physician, who are at risk for a Long Term Care admission, who are in need of home and community care services and whose annual income is at or below 250% FPL.

n. **Budget Population 21 - Young Adults Aging out of Katie Beckett:** young adults age 19-21 aging out of the Katie Beckett eligibility group with incomes below 250 % of FPL who are otherwise ineligible for Medical Assistance and in need of services and/or treatment for behavioral health, medical or developmental diagnoses.
o. **Budget Population 22 - Coverage for People Incarcerated pending Disposition of Charges:** The Waiver Extension Request seeks to extend Medicaid payment for services to otherwise eligible Medicaid beneficiaries who are incarcerated while their cases are pending.
p. **Budget Population 23 –** Healthy Works: The State of Rhode Island requests the authority under Section 1115 to obtain federal matching funds for employment supports and work rewards not available under a Section 1915(c) waiver or Section 1915(i) State Plan option to participants in the Healthy Works II pilot. Additionally, the state seeks the authority to include in adults with income from 133% to 200% in the target populations.

6. RIte Share [Budget Services 2]: Expenditures for part or all of the cost of private insurance premiums and cost sharing for eligible individuals which are determined to be cost-effective using State-developed tests that may differ from otherwise applicable tests for cost-effectiveness.
7. Window Replacement [Budget Services 1]: Expenditures for window replacement for homes which are the primary residence of eligible children who are lead poisoned.
8. Demonstration Benefits: Expenditures for benefits specified in the current 1115 Demonstration and this 1115 Waiver Extension request, which are not otherwise available in the Medicaid State Plan.
9. Expenditures for Healthy Choice Accounts and Healthy Choice incentives.
10. Expenditures for the provision of HCBS waiver-like services that are not otherwise available under the approved State plan, net of beneficiary post-eligibility responsibility for the cost of care.
11. Expenditures for core and preventive services for Medicaid eligible at risk youth (Budget Services 4).
12. Expenditures not to exceed on an annual basis $2.4 million total computable (federal and non-federal) for payments to Federally Qualified Health Centers (FQHCs) for uninsured populations. (Budget Services 5)
13. Extended eligibility for persons transitioning between Medicaid/CHIP and QHPs in the Exchange. Expenditures for persons who are transitioning from Medicaid or CHIP to a Qualified Health Plan (QHP) through the Exchange until enrollment in a QHP begins. The State is seeks a Waiver Authority of Comparability of Eligibility Standards Section 1902(a)(17).
14. Extend MAGI Medicaid renewals between 1/1/2013-3/31/2014. Expenditures for clients who would come up for redetermination between January 1, 2014 and March 31, 2014 by up to three months.

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

Title XIX Requirements Not Applicable to Budget Population 5:

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

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

CHIP Expenditure Authority

1. Expenditures for medical assistance for children through age 18 whose family income is equal to or less than 250 percent of the Federal Poverty Level (FPL) and who are not otherwise eligible under the approved Medicaid State Plan.

SECTION IX. PUBLIC NOTICE

In accordance with the notice requirements set forth in 42 CFR 431.408, Rhode Island initiated a public comment period for its 1115 waiver extension request. The state provided a thirty-day public notice and review period, beginning on January 18, 2013 and ending on March 1, 2013. Public notice of the application was published in the *Providence Journal*, the daily newspaper with the widest circulation in the state. The application, descriptions of the public notice process, public input on the waiver, and the public hearing schedule were also posted on the state's website at:
http://www.eohhs.ri.gov/ri1115waiver/updates/

The state held three (3) public hearings in separate parts of the state. One of the hearings was cancelled due to a snow storm, so an additional public hearing was added on February 19, 2013.

Public hearing #1:
January 28, 2013 from 1:00 to 3:00 pm at the Medicaid Waiver Taskforce Meeting held at the Arnold Conference Center, Cranston, RI

There were a total of 72 people that attended. Twenty were Taskforce members, 35 were interested stakeholders, and 17 were State EOHHS staff. There were five (5) public comments from the first public hearing; four (4) provided written comments and one (1) provided oral comments only. They are reflected on the Public Comments page on the website. See link below.

Public hearing #2:
February 8, 2013 from 4:00 to 6:00 pm held at the Department of Health Auditorium, Providence, RI. (CANCELLED)

Public hearing #2 - Rescheduled:
February 19, 2013 from 4:00-6:00 pm held at the University of Rhode Island, Kingston, RI.

There were three (3) people that attended Public Hearing #4. One person prepared written comments and spoke and one person called in on the phone line and asked a question. The person that asked a question over the phone also submitted written comments at a later date.

The public was able to participate by conference call during the February 19, 2013 session.

The state used an electronic mailing list to notify the public of any events or changes related to the application. Any member of the public could submit public comments by (1) attending and speaking at a public hearing, (2) submitting written comments by mail or (3) by email.

Public hearing #3:
February 11, 2013 from 4:00-6:00 pm held at the Woonsocket City Hall, Woonsocket, RI

There were 11 people that attended this public hearing. One member gave public comments and submitted comments in writing.

All public comments received during the 30-day comment period and the public hearings that were held are posted on the state's website under "Public Comments."

http://www.ohhs.ri.gov/ri1115waiver/publiccomments/ A summary of the public process and the State's responses to public comments are attached as an appendix.

In compliance with federal directives regarding "consultation and coordination with Indian and Tribal governments," the state contacted the Narragansett Tribe on January 11, 2013. The Narragansett Tribe is Rhode Island's only federally recognized Indian Tribe. The state announced its intention to submit the waiver application by certified letter. This letter is attached as an appendix. As of 3/8/13, there has been no response from the tribe.

ATTACHMENT A - 1115 Waiver Category Changes

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

ATTACHMENT B – CARRY FORWARD ALL STATE PLAN AND DEMONSTRATION BENEFITS

All State Plan services are included in this Waiver Extension.

All Demonstration only benefits included in the current 1115 Demonstration will remain in this Waiver Extension.

ATTACHMENT C – CORE AND PREVENTIVE HOME AND COMMUNITY BASED SERVICE DEFINITIONS

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

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

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

2. A Personal Care Attendant via Employer Authority under the Self Direction option.

Environmental Modifications (Home Accessibility Adaptations):
Those physical adaptations to the home of the member or the member's family as required by the member's service plan, that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home and to avoid institutionalization, and are not covered or available under any other funding source. A completed home assessment by a specially trained and certified rehabilitation professional is also required. Such adaptations may include the installation of modular ramps, grab-bars, vertical platform lifts and interior stair lifts. Excluded are those adaptations that are of general utility, and are not of direct medical or remedial benefit to the member. Excluded is any re-modeling, construction, or structural changes to the home, (i.e. changes in load bearing walls or structures) that would require a structural engineer, architect and /or certification by a building inspector.

Adaptations that add to the total square footage of the home are excluded from this benefit. All shall be provided in accordance with applicable State or local building codes and prior approval on an individual basis by EOHHS, Office of Long Term Services and Supports is required.

Items should be of a nature that they are transferable if a member moves from his/her place of residence.

Special Medical Equipment: Special Medical Equipment and supplies to include Ceiling or Wall Mounted Patient Lift, Track System, tub slider system, rolling shower chair and/or Automatic Door Opener, which enable members to increase their ability to perform activities of daily living, including such other durable and non-durable medical equipment not available under the Medicaid-funded primary and acute care system* that

is necessary to address member functional limitations. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid-funded primary and acute care system* and exclude those items that are not of direct medical or remedial benefit to the member. All items shall meet applicable standards of manufacture, design and installation. Provision of Special Medical Equipment requires prior approval on an individual basis by EOHHS, Office of Long Term Services and Supports and a home assessment completed by a specially trained and certified rehabilitation professional. Items should be of a nature that they are transferable if a member moves from his/her place of residence. Excluded is any re-modeling, construction, or structural changes to the home, (i.e. changes in load bearing walls or structures) that would require a structural engineer, architect and /or certification by a building inspector.

Minor Environmental Modifications: Minor Environmental modifications 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 adaptation, health or safety.

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

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

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.

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

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.

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 but are not limited to: 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.

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

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: Individual employment support services are the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job. Supported employment services are individualized and may include any combination of the following services: vocational/job related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, asset development and career advancement services, and other workplace support services including services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

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 service plan. These services are provided to an individual at home and require and assessment to be completed by a Registered Nurse (RN) from the Office of Community Programs.

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.

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.

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.

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.

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

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

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

ATTACHMENT D: COST SHARING CHART

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

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

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

- Cost-sharing for BBA working disabled adults defined in section 1902(a)(10)(A)(ii)(XIII) will follow the Medicaid State Plan
- All unearned income over the Medically Needy Income Limit (MNIL) will be owed as a monthly premium;
- Cost-Sharing for [Elders 65 and over] At risk for LTC with income at or below 250 percent of the FPL who are in need of home and community-based services (state only group) is to be treated like post-eligibility treatment of income or spend down requirements.

ATTACHMENT E: LEVEL OF CARE CRITERIA
Long-term Care Level of Care Determination Process

LTC Level of Care and Service Option Matrix		
Highest Nursing Home Level of Care (Access to Nursing Facilities, all Community- Based Services)	**Highest Hospital Level of Care** (Access to Hospital, Group Homes, Residential Treatment Centers, all Community-Based Services)	**Highest ICFMR Level of Care** (Access to ICFMR, Group Homes and all Community Based Services)
High Nursing Home Level of Care (Access to Core, Preventive Community-Based Services)	**High Hospital Level of Care** (Access to Core, Preventive, Community-Based Services)	**High ICFMR Level of Care** (Access to Core and Preventive Community-Based Services)
Preventive Nursing Home Level of Care (Access to Preventive Community-Based Services)	**Preventive Hospital Level of Care** (Access to Preventive Community-Based Services)	**Preventive ICFMR Level of Care** (Access to Preventive Community-Based Services)

ATTACHMENT F – RHODE ISLAND'S INTEGRATED CARE INITIATIVE

In January 2013 the state submitted a Category Change II request for authority for our Integrated Care Initiative (ICI). The ICI is included here in order to carry authority forward into the waiver renewal period and to highlight our focus on coordinated delivery systems. EOHHS's Integrated Care Initiative is designed for adults with disabilities eligible for Medicaid only and for adults eligible for both Medicaid/Medicare benefits. The Integrated Care Initiative is intended to ensure that services are delivered in the most appropriate care setting for each member based on their medical, behavioral health, and social service needs.

Our goal is to improve quality and value by:

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

Initially, the state will procure vendors to integrate acute, primary and specialty care with long-term care services and supports. This procurement was issued in February 2013 with initial enrollment slated for September 2013. In order to achieve full integration (primary care, acute care, specialty care, behavioral health care, and long-term services and supports) the state is proposing to follow two primary pathways. As described below, this approach will promote consumer choice and ensure accountability, access, and improved outcomes for Medicare and Medicaid Eligible (MME) members, particularly those members requiring long-term care services and supports. The state will pursue both major pathways in parallel. Enrollment in one of the two models will be mandatory.

- **<u>Enhanced PCCM Model</u>**
  The Enhanced PCCM Model, **Connect Care Choice *Community Partners (*CCC*CP)***, builds on the Connect Care Choice (CCC) Primary Care Case Management (PCCM) program's demonstrated capacity and experience to serve individuals with complex medical conditions. Currently, 17 CCC practice sites, meeting standards of performance adopted from the chronic care model of "best practices" serve approximately 1,800 Medicaid-only beneficiaries across Rhode Island. The CCC model encompasses primary care/nurse case management teams and co-located behavioral health services to provide quality focused and holistic care to beneficiaries. CCC is designed to achieve and preserve access to primary, preventive, behavioral health, and specialty care that allows the individual to remain well and independent in the community and decrease unnecessary acute episodes of care.

  To address the needs for greater integration of primary care, acute care, specialty care, behavioral health, and long-term care services and for high-touch care coordination, the state will contract with a **Coordinating Care Entity (CCE)** that will both (a) oversee and manage the performance data, quality assurance, and quality improvement activities and (b) will

deploy a **Community Health Team (CHT)** that will coordinate the social supports and services for the Medicaid-only and MME members. The CCE will work closely with the existing CCC Nurse Care Managers integrated in the CCC Primary Care Practice sites and with the EOHHS Office of Community Programs (OCP) Nurse Care Managers to develop and implement a plan of care and to provide links to social supports for a coordinated, seamless delivery system. The LTSS services that are currently funded and managed through the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) will continue to be funded and managed through BHDDH. The CCC*CP* team will coordinate these services with the BHDDH social caseworker and the BHDDH support coordinator.

- **Managed Care Organizations**

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

  This model will be implemented in two phases:

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

  During Phase I all MME individuals in these groups will be enrolled in a health plan. However, services that are currently funded and managed through BHDDH will continue unchanged during this period.

  Phase II includes the provision of all Medicaid-covered benefits to the Medicaid-only adults who receive LTSS and to the full benefit MMEs population. Phase II includes the provision of all Medicaid benefits to the Medicaid only and, through CMS's Financial Alignment Demonstration, Medicaid and Medicare benefits to dually eligible Medicaid and Medicare individuals.

Through implementation of Rhody Health Options and Connect Care Choice Community Partners we will take significant action to improve systems of care and support for our most vulnerable citizens.

With implementation of the ICI, all persons in the participating populations will be enrolled in enhanced systems of care that have defined accountability standards for performance. In Phase II, fragmentation in the experience of care will be further reduced through the shared financial alignment with Medicare.

ATTACHMENT G

EVALUATION STATUS AND FINDINGS FOR THE GLOBAL CONSUMER CHOICE COMPACT SECTION 1115 WAIVER NO. 11-W-00242/1

Executive Office of Health and Human Services (EOHHS)

State of Rhode Island and Providence Plantations

January 2013

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CHAPTER I

BACKGROUND ON THE DEMONSTRATION PROJECT

The Rhode Island Medicaid Reform Act of 2008, established a series of goals for transforming the State's Medicaid program into "a sustainable, cost-effective, person-centered and opportunity-driven program"(Section 42-12.4-2 Rhode Island General Laws). Toward this end, the Act directed the Executive Office of Health and Human Services to seek the necessary authorities to redesign the program by applying for a "global" demonstration under Section 1115(a) of Title XI of the Social Security Act.

The initial application for the demonstration was submitted by the Medicaid State agency on August 8, 2008. On January 16, 2009, the State was granted a Section 1115 waiver (11-W-00242/1) for the Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration. Under the terms and conditions of the waiver, the demonstration expires on December 31, 2013.

1.1 Demonstration Description

Rhode Island's Global Consumer Choice Compact Demonstration (the Demonstration) established a new federal-state compact providing the State with substantially greater flexibility than was available under program guidelines at the time of the waiver application submission. The State planned to use the additional flexibility afforded by the Demonstration to redesign the Medicaid program to provide cost-effective services to beneficiaries at the right time and in the most appropriate and least restrictive setting. In exchange for the increased flexibility and the opportunity to invest in Medicaid reform, the State assumed a degree of financial risk with respect to caseload and per member per month cost trends by committing to operate the program during the Demonstration under a mutually agreed upon five-year aggregate cap of federal funds.

Accordingly, Rhode Island has been operating its entire Medicaid program under this single Section 1115 demonstration project. (Disproportionate share hospital (DSH) payments and payments to local education agencies (LEAs) are excluded and were not included in the original waiver application.[16]) All Medicaid-funded services on the continuum of care – from preventive care in the home and community to care in high-intensity hospital settings to long-term and end-of life-care – are organized, financed, and delivered through the Demonstration at this time. Rhode Island's Section 1115 RIte Care and RIte Share programs for children and families, the 1915(b) Dental Waiver (RIte Smiles), and the Section 1915(c) Home and Community Based Services waivers have been incorporated into the Global Consumer Choice Compact Demonstration as well.

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

Under the Special Terms and Conditions (STCs) of the Demonstration, the State has flexibility to make changes to the Medicaid program in accordance with the categories set forth in Paragraph 17 of the STCs:

PROCESS FOR MODIFYING THE MEDICAID PROGRAM UNDER THE DEMONSTRATION		
Category I	**Category II**	**Category III**
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	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 spend-down eligibility). The State must comply with its existing public notice process prior to implementation, and must comply with the section 1115 demonstration public notice process as described in paragraph 14 of the STCs or in effect in federal regulations at the time of the change.	A change requiring modifications to the current waiver or expenditure authorities including descriptive language within those authorities and the STCs, and any other change that is not clearly described within Categories I and II. In addition, a programmatic change may be categorized as a Category III change by the State to obtain reconsideration after unsuccessfully pursuing approval of the change under Category II. The State must comply with the section 1115 demonstration public notice process as described in paragraph 14 of these STCs. The State must notify CMS in writing of Category III changes, and submit an amendment to the demonstration as described in paragraph 18: "Process for Changes to the Demonstration". Category III changes shall not be implemented until after approval of the amendment by CMS.

CHAPTER II

GOALS AND OBJECTIVES OF THE DEMONSTRATION

Under the Global Consumer Choice Compact as approved by our federal partners, the State obtained the authorities necessary to pursue many of the changes in the Medicaid program outlined in the Medicaid Reform Act. Key reform targets included:

- Rebalancing the publicly-funded long-term care system in order to increase access to home and community-based services and supports and to decrease reliance on inappropriate institutional stays
- Ensuring that all Medicaid beneficiaries have access to a medical home
- Implementing payment and purchasing strategies that align with programmatic goals and support a sustainable, cost-effective program
- Providing an accessible and comprehensive system of coordinated care that focuses on independence and choice
- Maximizing available service options
- Promoting accountability and transparency
- Encouraging and rewarding healthy outcomes
- Advancing efficiencies through interdepartmental cooperation

With these target areas in mind, the evaluation design for the Demonstration established , a set of goals, objectives, and evaluation questions to address the five (5) major components of the State's Global Consumer Choice Waiver: Long-term care; RIte Care; RIte Share; Extended Family Planning; and Expansion (Costs Not Otherwise Matchable/CNOM) Groups.

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

- **Long-term Care Goal 1:** To undertake measurable reform of Rhode Island Medicaid's long-term care program.

    - **Objective 1:** To rebalance the State's existing long-term care system with home- and community-based services

    - **Objective 2:** To increase the utilization of home- and community-based services in Rhode Island

    - **Objective 3:** To modify the State's income and resource eligibility requirements for Medicaid-funded long-term care services, specifically the rules pertaining to institutionalized spouses and continuous periods of institutionalization

- **Long-term Care Goal 2:** To establish objective, needs-based level of care determinations for Medicaid long-term care applicants and beneficiaries.

    - **Objective 1:** To develop systems for the delivery of needs-based level of care determinations for Medicaid LTC applicants and beneficiaries focused upon identifying applicants' medical, behavioral and social needs which could impact their ability to remain safely in home- and community-based settings

- **Long-term Care Goal 3:** To limit the rate of growth of the State's Medicaid budget.

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

    - **Objective 2:** To implement selective contracting based upon Rhode Island's purchasing analyses

    - **Objective 3:** To prevent or delay growth in Medicaid eligibility for full benefits by instituting Medicaid claiming for selected populations and/or services using costs not otherwise matchable (CNOM) authority

    - **Objective 4:** To promote the delivery of case management services for beneficiaries through organized systems of care

- **RIte Care Goal 1:** To increase access to and improve the quality of care for Medicaid families eligible for the Demonstration.

    - **Objective 1:** To reduce un-insurance in the expansion population groups eligible for the Demonstration

- **RIte Care Goal 2:** To expand access to health coverage to all eligible pregnant women and all eligible uninsured children and adults.

    - **Objective 1:** To provide all enrollees in the Demonstration with a *medical home*

    - **Objective 2:** To improve access to health care for populations eligible for the Demonstration

    - **Objective 3:** To increase the appropriate use of inpatient hospitals and hospital emergency departments

    - **Objective 4:** To reduce infant mortality

- **Objective 5:** To improve maternal and child health outcomes

- **Objective 6:** To have a high satisfaction level with the Demonstration project among enrolled populations

- **RIte Share Goal 1:** To expand access to health coverage to all eligible pregnant women and all eligible uninsured children and adults.
  - **Objective 1:** To provide a cost-effective alternative to Medicaid eligibility through mandatory participation in employer-sponsored insurance (ESI)

- **Extended Family Planning Goal 1:** To control the rate of growth in the Medicaid budget for the eligible population.
  - **Objective 1:** To avert future Medicaid-funded births by providing family planning services to Medicaid-eligible women who lost their Medicaid eligibility 60 days post-partum

  - **Objective 2:** To increase the inter-birth spacing for Medicaid-funded births by providing family planning services to Medicaid-eligible women who lost their Medicaid eligibility 60 days post-partum

- **CNOM Budget Population Goal 1:** To increase access to and improve the quality of care for Medicaid families eligible for the Demonstration.
  - **Objective 1:** To reduce un-insurance in the expansion population groups eligible for the Demonstration

- **CNOM Budget Population Goal 2:** To expand access to health coverage to all eligible pregnant women and all eligible uninsured children and adults.
  - **Objective 1:** To provide all enrollees in the Demonstration with a *medical home*

  - **Objective 2:** To improve access to health care for populations eligible for the Demonstration

  - **Objective 3:** To increase the appropriate use of inpatient hospitals and hospital emergency departments

  - **Objective 4:** To reduce infant mortality

- **Objective 5:** To improve maternal and child health outcomes

- **Objective 6:** To have a high satisfaction level with the Demonstration project among enrolled populations

- **CNOM Budget Population 9 & Budget Services Group 4 Goal 1:** To provide a limited benefit package for children with special health care needs (CSHCN) who have not been voluntarily placed in State, custody, thereby allowing them to function in the least restrictive environment.

  - **Objective 1:** To provide a cost-effective, home- and community-based alternative to institutional care for CSHCN

- **CNOM Budget Population 10 Goal 1:** To assist elders over the age of 65 to maintain optimum health and functioning in the least restrictive environment by providing home- and community-based services to qualified beneficiaries.

  - **Objective 1:** To improve beneficiary stability and functioning in the community

  - **Objective 2:** To provide a cost-effective alternative to institutional care

- **CNOM Budget Population 15 Goal 1:** To provide a limited benefit package for adults with disabilities who are at risk for long-term care (LTC), thereby promoting their ability to function in the least restrictive environment

  - **Objective 1:** To increase adults with disabilities' access to a designated set of home- and community-based services

  - **Objective 2:** To provide a cost-effective, home- and community-based alternative to institutional care for adults with disabilities

- **CNOM Budget Population 16 Goal 1:** To provide cost-effective services that will ensure recipients receive the appropriate services in the least restrictive and most appropriate setting

  - **Objective 1:** To increase access for uninsured adults with mental illness and/or substance abuse problems to a designated set of community-based services

  - **Objective 2:** To reduce the number of Medicaid-paid psychiatric inpatient admissions for drug/alcohol admissions for drug/alcohol detoxification

- **Objective 3**: To reduce the average inpatient MI/SA length of stay (ALOS)

- **Objective 4:** To reduce inpatient readmissions within 30 days of MI/SA hospital discharges

- **CNOM Budget Population 17 Goal 1:** To provide a limited benefit package for children less than 18 years of age who are at risk of institutional care, thereby allowing these children to live in the least restrictive environment.

  - To increase access for children at risk of requiring institutional care who are not Medicaid eligible to a designated set of home- and community-based services available to Budget Population 17

  - To provide a cost-effective home- and community-based alternative to institutional care for children less than 18 years of age who are at risk of institutional care

CHAPTER III

DEMOSTRATION EVAUATION REQUIREMENTS

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

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

Among the specific aspects of the Demonstration that must be included in the evaluation under the STCS are the following:

Comprehensive Evaluation -- Global Waiver Demonstration: A discussion of the goals, objectives, evaluation questions, and outcome measures used to assess the entire Demonstration as well as 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.

Focused Evaluation: The separate components of the Demonstration identified for evaluation in the STCs included:

a) LTC Reform, including the HCBS-like and PACE-like programs;
b) RIte Care;
c) RIte Share;
d) The 1115 Expansion Programs (Limited Benefit Programs), including but limited to:
   (1) Children and Families in Managed Care and Continued eligibility for RIte Care parents when children are in temporary state custody;
   (2) Children with Special Health Care Needs;
   (3) Elders 65 and Over;
   (4) HCBS for Frail Elders, adults with disabilities, children in residential diversion and at risk/Medicaid eligible youth;
   (5) Uninsured adults with behavioral health and 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[17]

It should also be noted that Paragraph 98 of the STCs provides:

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

Therefore, the evaluation design document required by the STCS did not specify the State to address explicitly the home- and community-based services system except where tied to long-term care reform or CNOM populations.

Additional evaluation requirements set forth in the STCS focus on expiration of the Demonstration. Specifically, Paragraph 96-c of the STCS requires the state to "submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration." In turn, CMS must provide comments on the report within 60 days of receipt.

Based on these requirements, the Rhode Island Executive Office of Health and Human Services (EOHHS) prepared and submitted the required Draft Evaluation Plan to CMS on July 17, 2009.[18]

[17] The draft design must include a discussion of the goals, objectives and evaluation questions specific to this component of the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the extended family planning program, particularly among the target family planning population, during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the extended family planning program shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation. The report should also include an integrated presentation and discussion of the specific evaluation questions (including those that focus specifically on the target population for the family planning program) that are being tested. At a minimum, the following data elements will be included in the measurement methodology: Enrollment; averted births; inter-birth spacing; and family planning patients receiving a clinical referral for primary care.

[18] As there was no feedback from CMS on the document, we proceeded to implement the evaluation design as submitted.

CHAPTER IV

DEMOSTRATION EVALUATION DESIGN AND STATUS

4.1 Demonstration Evaluation Design

After award of the Demonstration, EOHHS formed a Global Waiver Quality and Evaluation Workgroup, which has met continually, usually on a monthly basis. The Workgroup is comprised of representatives from the EOHHS and the various departments involved in Medicaid under the office's umbrella as well as contractor representatives. Initially, the Workgroup took up the drafting of the required evaluation design. The July 17, 2009 *Draft Evaluation Design* submitted to CMS had a separate evaluation design for the following program components:

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

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

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

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

- RIte Care Demonstration Project Evaluation Design

- Extended Family Planning Program (EFP) Evaluation Design

A detailed evaluation design for each program component of the Demonstration is posted to the EOHHS Website.

4.2 Demonstration Evaluation Status

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

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

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

Table 1

Status of the Evaluation Design

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

The EOHHS also submits a quarterly report to the Rhode Island General Assembly's Senate Committee on Health and Human Services.[19] These reports form a substantial part of the Global Waiver quarterly report submissions to CMS.

[19] These reports are posted on the EOHHS Website and may be accessed at: http://www.eohhs.ri.gov/documents/documents12/Senate_Quarterly_Report_09_28_12.pdf

CHAPTER V

DEMOSTRATION EVALUATION FINDINGS

This chapter presents evaluation findings for:

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

1. Long-Term Care Evaluation Findings

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

- **Long Term Care (LTC) System Costs**: Have Global Waiver and budget initiatives focusing on Rhode Island's long-term care processes, procedures, and provider payments affected enrollment, utilization, and cost of services and supports provided to the elderly and adults with disabilities in home and community based versus institutional settings?

- **Enhanced Care Management:** Have Global Waiver initiatives designed to reduce cost through care management by providing each Medicaid beneficiary with a medical home affected Medicaid expenditures and improved health outcomes, particularly for those beneficiaries with disabilities?

- **System Redesign and Rebalancing**: Have the Global Waiver initiatives facilitated the State's efforts to ensure every Medicaid beneficiary has the right services, at the right time, in the right setting?

With respect to LTC cost and utilization, the Global Waiver built on the State's strategic plan to rebalance the LTC services and supports initiated through the State's Real Choices Systems Transformation Grant which began in 2006. The initiatives to rebalance the LTC system included:

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

- Improving shared living arrangements

The Lewin Group analyzed Medicaid claims data for State Fiscal Years (SFY) 2008 through 2010 related to these factors and concluded:

This analysis of LTC expenditures found that the Global Waiver was successful in re-balancing the long term care system resulting in utilization of more appropriate LTC services. During the study period the average number of nursing home users fell by 3.0 percent from SFY08 to SFY10. During the same period the average number of home and community base service users rose by 9.5 percent. These Global Waiver strategies clearly helped the state to re-balance the delivery of LTC services, resulting in savings of $35.7 million during the three year study period according to our estimates.[20]

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

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

In examining the impact of implementing these initiatives, The Lewin Group found:

The average cost per day in a nursing home rose by an average of 1.1 percent during the study period, while the acuity of the enrolled population rose by more than 5 percent. The increase was consistent with the inflation rate during this period. The increase in the acuity of the enrolled population was the result of the Global waiver home diversion and transition initiatives. The rate initiatives resulted in savings of $15 million according to our estimates during SFY10. [21]

To assess the impact of the State's efforts under the Demonstration related to care management, The Lewin Group considered the mandatory enrollment of children with special health care needs (CSHCN) and adults with disabilities into managed care during SFY10 to ensure that every beneficiary had a medical home. CSHCN were enrolled in RIte Care and the adults with disabilities were enrolled in either Rhody Health Partners or Connect Care Choice. The Lewin Group determined:

Analyses of total expenditures for members in these programs in comparison to members in unmanaged fee for service found that these case management programs were clearly cost effective. An analysis of the utilization of medical services by members enrolled in care management programs found evidence of lower emergency room utilization and improved access to physician services. These programs resulted in savings in excess of $5 million during SFY10, based on our most conservative estimates.[22]

[20]The Lewin Group. *An Independent Evaluation of Rhode Island's Global Waiver,* December 6, 2011 p.1
[21] *Ibid. p. 2.*
[22] *Ibid.*

Last, with respect to the right services, at the right time, in the right setting, The Lewin Group evaluation focused on a cohort of CSHCN and adults with disabilities transitioned to managed from SFY09 to SFY10. In reviewing the data on these beneficiaries, The Lewin Group found:

The utilization of inpatient care, emergency room visits and physician visits for members in the cohort was computed each year using claims and encounter data. All three groups experienced a decrease in the number of emergency room visits from SFY09 to SFY10 and an accompanying increase in the number of physician visits during SFY10. [23]

Upon completing its evaluation of the facets of the Global Waiver outlined here, The Lewin Group concluded: "In summary, the Global Waiver and budget initiatives introduced by the state have been highly effective in controlling Medicaid costs in Rhode Island and improving members' access to more appropriate services." [24]

A full copy of the evaluation entitled *An Independent Evaluation of Rhode Island's Global Waiver* can be accessed on the EOHHS' Website:
http://www.eohhs.ri.gov/documents/documents11/Lewin_report_12_6_11.pdf

2. RIte Care and Rhody Health Partners

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

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

Among the principal strengths identified for both Health Plans were their strong performances related to care access and the availability of well care and preventive screening services and generally high levels of member satisfaction, among other factors.

[23] Ibid.
[24] Ibid

A full copy the EQRO's most recent Aggregate report can be accessed on the EOHHS Website: http://www.eohhs.ri.gov.

The *Monitoring Quality and Access in RIte Care and Rhody Health Partners* report, which is produced annually, documents the performance measurement outcomes for thirty-nine (39) quality measures that are analyzed in the State's Performance Goal Program for RIte Care and Rhody Health Partners. Our State's Performance Goal Program is the second oldest Medicaid "pay for performance" program in the United States. A full copy of the report can be accessed on the EOHHS Website: http://www.eohhs.ri.gov/documents/documents12/Monitoring_Quality_Access_10_2012.pdf

3. Extended Family Planning

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

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

- To avert future Medicaid-funded births by providing family planning services to Medicaid-eligible women who lost their Medicaid-eligibility 60 days post-partum

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

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

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

Table 2 (please refer to the following page), shows the number of averted births attributable to EFP from 1998 through 2010. As the table shows, there were 4,522 averted births over that time period.

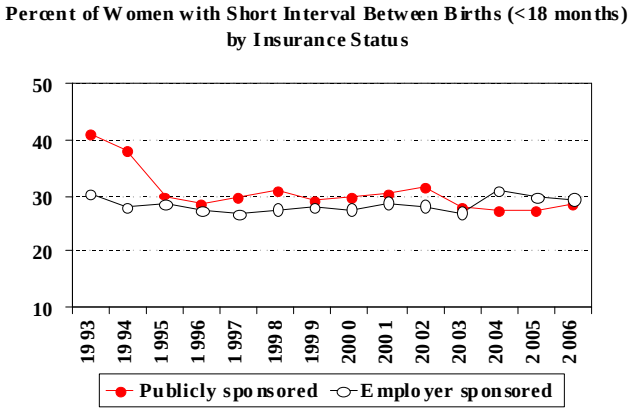
Table 2

RIte Care Averted Births: 1998 - 2010

Year	Expected RIte Care Births	Averted RIte Care Births	Cumulative Averted Births
1998	4,258	298	298
1999	4,637	645	943
2000	4,812	336	1,279
2001	5,108	472	1,751
2002	5,328	418	2,169
2003	5,416	300	2,469
2004	5,564	442	2,911
2005	5,622	391	3,302
2006	5,641	402	3,704
2007	5,376	102	3,806
2008	5,125	(15)	3,791
2009	5,132	240	4,031
2010	5,258	491	4,522

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

Figure 1



As noted earlier, the State was obligated by the STCs to conduct a survey of EFP enrollees referrals for primary care. The sample universe for the survey consisted of women continuously enrolled in EFP for 330 to 365 days from January 2010 through June 2011. There were 673 such women. After eliminating women with no telephone or

who did not speak English, the final sample universe was 221 women from which the random sample of 30 completed surveys were done.

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

Table 3

EFP Survey Calls

Outcome of Call	Number
Answering Machine	34
Completed Survey	30
Not in Service	13
No Answer	12
Spoke Spanish	9
Not Home	7
Wrong Number	5
Call Back	4
Busy Signal	3
No Incoming Calls	2
Total	**119**

The responses to the survey are shown below.

Figure 2 shows that that the vast majority of women surveyed had a family planning visit after the birth of their child.

Figure 2

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

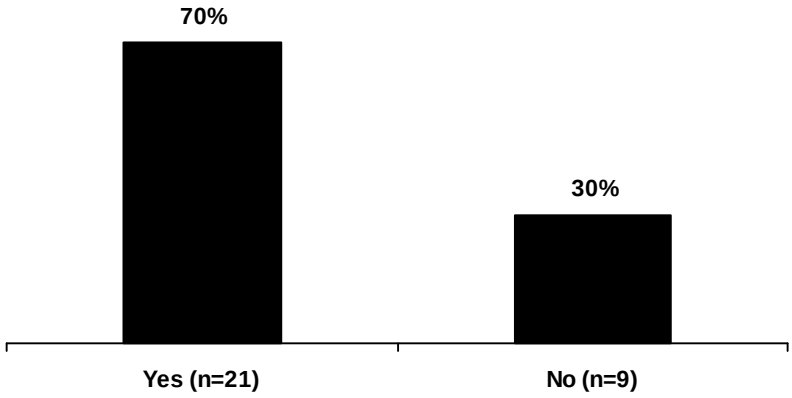


Figure 3, shown below, notes that only four respondents reported that they had been referred for a primary care visit (clinical referral) while they were at a family planning visit.

Figure 3

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

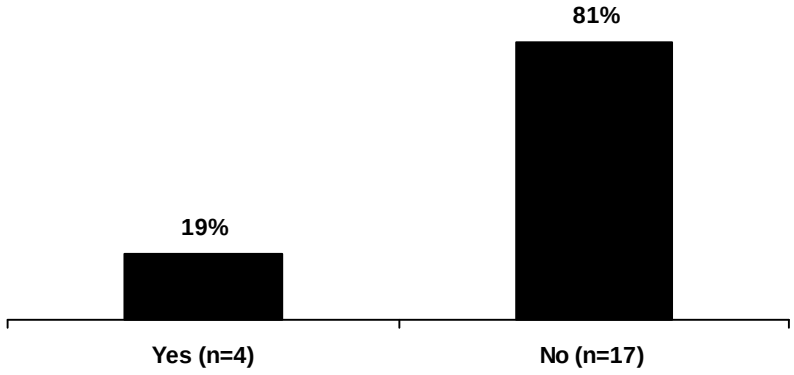


Figure 4 shows that for three of the four respondents who were referred for a primary care visit (clinical referral), they were referred to a physician's office, and the other to a community health center.

Figure 4

Where were you referred for Primary Care?

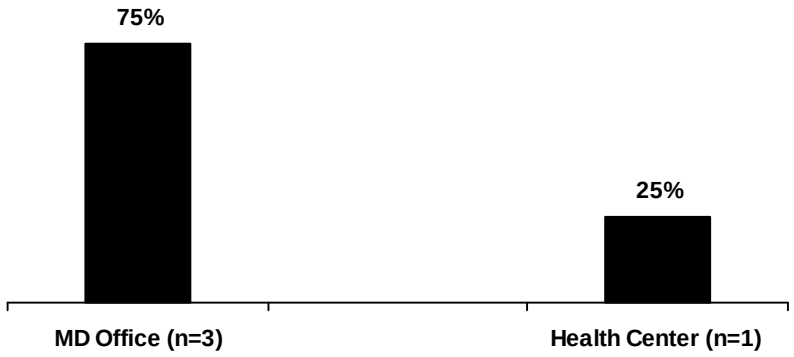
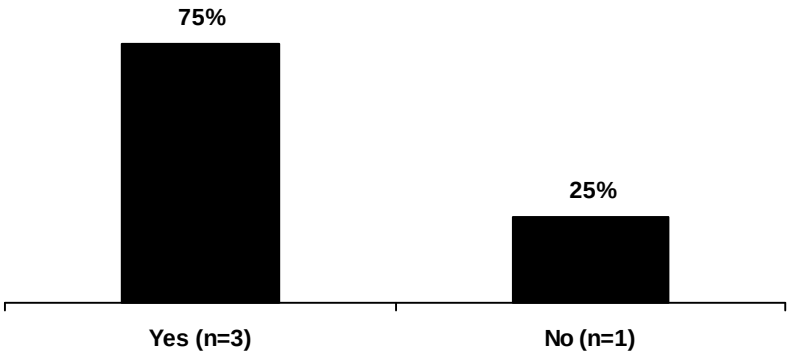


Figure 5, shown on the following page, notes that for three of the four respondents who were referred for a primary care visit (clinical referral), they went for the primary care visit, and the other did not.

Figure 5

Did you go for a Primary Care Visit after referral?



ATTACHMENT H: QUALITY MONITORING & EXTERNAL QUALITY REVIEW ORGANIZATION REPORTS

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

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

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

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

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

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

- Each Health Plan's accreditation survey findings from the National Committee on Quality Assurance[25]
- Each Health Plan's final, audited annual HEDIS®[26] scores and the report from its independent NCQA-certified HEDIS® auditor
- Provider network analyses: GeoAccess
- Each Health Plan's contractually-mandated Quality Improvement Projects (QIPs)
- Health Plans' performance in Rhode Island's annual Performance Goal Program
- **Each Health Plan's annual CAHPS®[27] member satisfaction survey report from the Health Plan's NCQA-certified CAHPS® auditor**
- **Each Health Plan's Quality Improvement/Quality Management Program Evaluation (which may also be referred to as the Health Plan's annual QI report)**
- **The Health Plan's Quality Improvement/Quality Management Plan**
- **Any special studies (such as CAHPS® Clinician and Group Surveys or ECHO Surveys)**

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

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

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

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

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

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

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

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

> *"IPRO's external quality review concludes that the Rhode Island Medicaid Managed care program and its participating Health Plans, NHPRI and UHCP-RI, have had an overall positive impact on the accessibility, timeliness and quality of services for Medicaid recipients."*[28]

A version of the most recent Aggregate EQR report has been posted to the EOHHS Website and can be accessed at the following link:
http://www.ohhs.ri.gov/documents/documents13/Aggregate_EQR_Report.pdf

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

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

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

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

During the Autumn of 2011, Rhode Island Medicaid initiated an enhancement to its Quality Strategy. Building upon the core principles that had been previously approved by CMS for RIte Care, Rhode Island initiated this process in order to address the State's newer Medicaid managed

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

care programs: RIte Smiles, Connect Care Choice, and Rhody Health Partners. To elicit the participation of key stakeholders, the State's Quality Strategy was presented to the Global Waiver's Quality and Evaluation Work Group on 04/13/2012, to Rhode Island Medicaid's Consumer Advisory Committee (CAC) on 05/10/2012, and to Rhode Island Medicaid's senior administrators on 10/24/2012. To further engage with consumers and other key stakeholders, the proposed revision was also posted on the Rhode Island EOHHS Web-site. A copy of the Power Point presentation that was made to RI Medicaid Consumer Advisory Committee (CAC) on May 10, 2012, has been posted to the EOHHS Website. This presentation can be accessed at the following link:
http://www.ohhs.ri.gov/documents/documents13/Update_RI_Quality_Strategy_for_Managed_Care.pdf

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

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

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

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

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

- **State Liaisons:** Highly qualified individuals who have managed care experience and intimate knowledge of the RI Medicaid program are assigned to each MCO (including UHC Dental). These professionals serve as the chief liaison between the MCO and RI

Medicaid. Responsibilities include: monitoring compliance and contract performance, identifying any problem areas, assisting in the development and implementation of corrective action plans, providing technical assistance to improve cost-effectiveness and ensuring that MCOs are addressing any changes in Federal and State rules and regulations.

- **Analytics:** Medicaid program requirements are complex and require reporting and analysis of timely information and data regarding the performance of each MCO. MCOs are required to submit information about financials, operations and service utilization through the encounter data system. (RI Medicaid maintains and operates a data validation plan to assure the accuracy of encounter data submissions). The MCOs are also required to submit a series of quarterly reports, such as those that provide information regarding the adjudication of informal complaints, grievances and appeals. RI Medicaid staff analyze MCO data and compare it to established standards/measures, industry norms and trends to identify areas that need to be reviewed to improve compliance with established standards and/or to improve program performance. Additionally, our staff utilizes data modeling techniques to assess the impact of current trends or alternative improvement strategies.

- **Ongoing Evaluation/Review of Program Priorities & MCO Performance:** RI Medicaid conducts monthly internal staff meetings to discuss MCOs' attainment of performance goals and standards related to access, quality, health outcomes, member services, network capacity, medical management, program integrity and financial performance. RI Medicaid staff identifies strategies and develops recommendations for program improvements and assesses the feasibility and impact of potential changes in Medicaid to improve program operations.

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

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

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

- The design of a Quality Strategy which includes performance measures, methodology, and sampling strategy

- The monitoring of the implementation of the Quality Strategy and reporting on findings using performance measures
- The correction of non-compliance based on performance measures
- The implementation of corrective action when needed to improve performance

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

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

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

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

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

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

    - Utilization of services (reduced hospitalization and ED visits)
    - Participant and caregiver satisfaction
    - Outcome measures derived from data collected during participant assessments
    - Effectiveness and safety of staff-provided and contracted services
    - Non-clinical areas including grievances and appeals
    - Development and implementation of plans of action to improve or maintain quality of care

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

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

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

- Routine Immunizations
- Grievances and Appeals
- Enrollments
- Dis-enrollments

- Prospective Enrollees
- Readmissions
- Emergency (Unscheduled) Care
- Unusual Incidents, and
- Deaths

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

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

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

As described above, the rules governing PACE at the local level are prescribed by CMS (Medicare). A site visit is conducted by both CMS and the State every two years. The site visit is led by CMS, however internal clinical oversight is conducted by the State at as part of the site visit. For example, Grievance and Appeal adjudication is managed internally at PACE, but oversight of this process is a significant element of the CMS site visit, which is conducted in

collaboration with RI EOHHS. During the site visit, all relevant policies and protocols are reviewed, including the documentation of grievances and how each grievance was resolved.

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

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

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

- Member Services: Four (4) State-specified measures
- Medical Home/Preventive Care: Eighteen (18) measures[29]
- Women's Health: Two (2) HEDIS® measures
- Chronic Care: Four (4) HEDIS® measures
- Behavioral Health: Three (3) HEDIS® measures
- Cost Management: One State-specified measure
- Initial Health Screenings Are Completed within Contractual Timeframes: For new RIte Care for Children with Special Health Care Needs (CSHCN) and Rhody Health Partners Enrollees
- Care Management Plans Are Evaluated and Updated within Contractual Timeframes: For RIte Care for CSHCN and Rhody Health Partners Enrollees

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

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

Detailed written summaries are also presented to the Health Plans. Any areas warranting performance improvement are highlighted, both within the summary report and in the

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

accompanying cover correspondence. As noted previously, four (4) of the twelve (12) monthly Oversight and Monitoring meetings that are conducted with each Health Plan focus on quality improvement. At the August meeting, each Health Plan must present its action plan for remediation for any of the Performance Goal Program's HEDIS® or CAHPS® measures that do not meet the contractually-mandated Quality Compass for Medicaid® thresholds. Subsequently, at the December meeting, each Health Plan must outline the interventions that it will undertake to address any areas of low performance on any of the Performance Goal Program's State-specified measures.

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

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

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

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

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

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

- Each Health Plan must conduct four (4) Quality Improvement Projects annually
- At least one QIP must address each of the following populations of interest:

    - Children with Special Health Care Needs (CSHCN)
    - Disabled adults who are enrolled in Rhody Health Partners
    - Members who are enrolled in the Communities of Care initiative

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

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

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

State-mandated QIP Measures for CY 2013

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

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

- Screening Ratio
- Participant Ratio
- Total Eligibles Receiving Any Dental Services
- Total Eligibles Receiving Preventive Dental Services

- Total Eligibles Receiving Dental Treatment Services
- Total Eligibles Receiving a Sealant on a Permanent Molar Tooth
- Total Eligibles Receiving Dental Diagnostic Services
- Total Number of Screening Blood Lead Tests

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

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

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

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

The English text version[30] of Rhode Island's survey is posted to the EOHHS Website. In addition to using the standard CAHPS® survey instrument, RI Medicaid included several CAHPS® supplemental questions, focusing on the following content: Behavioral Health, Chronic Conditions, Mobility Impairments, and After-hours Care.

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

Managed Care Organization (MCO) Quality Monitoring – Accreditation by the National Committee for Quality Assurance (NCQA): Rhode Island has required its Medicaid-participating Health Plans to be accredited by the NCQA since the inception of our State's

[30] The survey was also available in Spanish text.

Medicaid managed care program in 1994. The NCQA is a private, 501(c)(3) not for profit organization, whose mission is to improve the quality of health care. Health Plans in every State, as well as the District of Columbia and Puerto Rico are NCQA accredited.

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

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

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

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

Health Plans are scored along five dimensions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medicaid Expansion

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

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

Health Homes

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

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

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

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

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

Integrated Care for Medicare and Medicaid Enrollees

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

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

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

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

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Appendix B

Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

Ms. Elena Nicolella
Medicaid Director
Executive Office of Health and Human Services
600 New London Avenue
Cranston, RI 02920

MAR 2 7 2013

Dear Ms. Nicolella:

Thank you for your recent request to extend the state's Global Consumer Choice Compact section 1115 demonstration (Project No. 11-W-00242/1). The Centers for Medicare & Medicaid Services (CMS) received your extension request on March 12, 2013. On April 27, 2012, CMS issued a final rule and guidance on section 1115 demonstration projects, outlining specific elements that need to be included in a state's extension request in order for CMS to determine that the request is complete. Once an extension request has been determined complete, CMS can begin the official review process, including initiation of the 30-day federal public comment period.

We have completed a preliminary review of your extension request in accordance with the April 27th final rule. As discussed with members of your staff, we have determined that the state's extension request has not met the requirements for a complete extension request as specified under section 42 CFR 431.412(c). In particular, please provide additional information regarding: (1) the state's plan for evaluation activities during the extension period including research hypotheses and an evaluation design regarding the state's proposed revisions to the demonstration; (2) a copy of the notice that the state published in the newspaper of widest circulation; and (3) a description of any additional mechanisms, such as electronic mailing lists, the state utilized to notify interested parties of the extension application.

During our review of the state's public notice process we determined that the draft extension request the state posted for public comment on its website did not include sufficient detail regarding budget neutrality. Specifically, the notice should have provided additional information regarding projected expenditures for the extension period, cumulative expenditures, projected enrollment, and a financial analysis of the requested changes to the demonstration. Please make all of the above identified information available for public comment pursuant to the public notice requirements in 42 CFR 431.408(a)(1).

We have also determined that, based on the information provided, the state did not meet the requirements under 42 CFR 431.408(b) regarding tribal consultation. Specifically, it does not appear that the state consulted with its federally-recognized Indian tribe as required by the final

rule and the state's approved tribal consultation state plan amendment (SPA). In accordance with 42 CFR 431.408(b), please consult with your federally-recognized Indian tribe using the process outlined in the approved tribal consultation SPA.

At this time, we will not begin our 30-day federal public comment and notice process as specified under 42 CFR 431.416(b). Once we receive a revised extension request that includes the missing elements, or explains how the current request addresses the missing elements, we will conduct another preliminary review to determine if the revised request is complete. We will notify you of our determination no later than 15 days after receipt of your revised extension request.

We look forward to working with you and your staff, and are available to provide technical assistance as you revise the state's extension request. If you have additional questions or concerns, please contact your project officer Ms. Jennifer Sheer, Division of State Demonstrations and Waivers, at (410) 786-1769, or at Jennifer.Sheer@cms.hhs.gov.

Sincerely,

Diane T. Gerrits
Director
Division of State Demonstrations and Waivers

cc: Jennifer Ryan, CMCS
Richard McGreal, ARA, CMS Boston Regional Office

Appendix C

RI EXECUTIVE OFFICE OF
HEALTH AND HUMAN SERVICES

NOTICE OF PUBLIC MEETING

The Executive Office of Health and Human Services will be hosting three Community Forums on **the Rhode Island Medicaid Section 1115 Waiver Extension Request.**

The following presentations will be on the status of the 1115 Waiver Extension Request and changes that have been made since the last submission in March 2013 to the Center for Medicare and Medicaid Services (CMS). Public comments will be welcome after the presentation. For more information and a copy of the draft Extension Request please see: http://www.ohhs.ri.gov/ri1115waiver/updates/

DATES AND LOCATIONS FOR THE COMMUNITY FORUMS:

July 17, 2013 from 4:00 to 6:00 pm*
University of Rhode Island, Alumni Hall, 73 Upper College Rd.
Kingston, Rhode Island 02881

July 22, 2013 from 1:00 to 3:00 pm
at the Medicaid Waiver Taskforce Meeting
RI Department of Labor and Training, Building # 73, Rm. 73-1
Cranston, RI 02920

July 25, 2013 from 4:00 to 6:00 pm
Woonsocket City Hall, Harris Hall, 169 Main St.
Woonsocket, RI 02895

* To participate by phone call, during the July 17th meeting only, please call: 1-866-628-8620, Pass code: 134136

If you need additional assistance or accommodations to attend any of these meetings please call: **(401) 462-2188** at least 48 hours in advance.

APPENDIX D

EVALUATION DESIGN FRAMEWORK FOR THE 1115 CHOICE WAIVER

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
Total Demonstration	To control the rate of growth of the State's Medicaid expenditures		Have the overall costs of providing Medicaid-covered services to population groups eligible prior to the Demonstration been controlled?	Total Medicaid Expenditures Subject to the 1115 Aggregate Cap	MMIS
Long-Term Care (LTC) Reform **(SECTION 4.1)**	**LTC 4.1**- To undertake measurable reform of Rhode Island Medicaid's long-term care program	**LTC 4.1.1**- To rebalance the State's existing long-term care system with home- and community-based services	**LTC 4.1.1.1**-Over the course of the 1115 Waiver, has there been a change in the number of admissions to LTC facilities (nursing facilities and ICF/MRs) paid by Medicaid?	Average Daily Census of Medicaid-paid Residents Who Are Aged or Disabled in Institutional Care	MMIS
			LTC 4.1.1.2- Over the course of the 1115 Waiver, has there been a change in the number and percentage of discharges from LTC facilities to home and community-based settings?	Medicaid-Paid Home and Community Based Care Utilization	MMIS
			LTC 4.1.1.3- Over the course of the 1115 Waiver, has there been a change in the average length of stay (ALOS) / in LTC facilities by Medicaid aged and disabled beneficiaries?	Medicaid-Paid Institutional Care Days	MMIS

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
Long-Term Care (LTC) Reform **(SECTION 4.1)**			**LTC 4.1.1.4-** Over the course of the 1115 Waiver, has the average daily census in LTC facilities (nursing facilities and ICF/MRs) changed for Medicaid aged and disabled beneficiaries?	Average Daily Census of Medicaid-paid Residents Who Are Aged or Disabled in Institutional Care	MMIS
			LTC 4.1.1.5- Has the cost of care provided to Medicaid aged and disabled beneficiaries in LTC facilities been controlled over time?	Medicaid Expenditures for Aged and Disabled Beneficiaries in Institutional Care	MMIS
		LTC 4.1.2- To increase the utilization of home- and community-based services in Rhode Island	**LTC 4.1.2.1-** Over the course of the 1115Waiver, has there been a change in the volume of beneficiaries receiving one or more core home- and community-based services, such as assisted living, private duty nursing, or shared living?	Medicaid-Paid Institutional Care Days	MMIS
				Medicaid Expenditures for Aged and Disabled Beneficiaries in Home and Community-Based Care	MMIS
			LTC 4.1.2.2- Over the course of the 1115 Waiver, has there been a change in the utilization of core home- and community-based	Aged and Beneficiary Enrollment in Systems of Care	MMIS
				Medicaid-Paid Home and	

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
Long-Term Care (LTC) Reform **(SECTION 4.1)**			services? **LTC 4.1.2.3**- Has the utilization distribution of Medicaid aged and disabled beneficiaries shifted between LTC facilities and home- and community-based care services? **LTC 4.1.2.4**- Has the cost distribution for Medicaid aged and disabled beneficiaries shifted between LTC facilities and home- and community-based services?	Community Based Care Utilization Number of clients who were approved to receive LTC facility-based services Medicaid Expenditures for Aged and Disabled Beneficiaries in Home and Community-Based Care Medicaid Expenditures for	MMIS MMIS MMIS
		LTC 4.1.3- To modify the State's income and resource eligibility requirements for Medicaid-funded long-term care services	**LTC 4.1.3.1**- How many Medicaid LTC applicants meet the revised financial eligibility thresholds based upon the State's new spousal impoverishment rules for individuals who are medically needy in special income-level group (i.e., Budget Populations 11, 12, and 13)?	Aged and Disabled Beneficiaries in Institutional Care Enrollment as of the End of the Reporting Period Number of clients who were approved to receive home- and community-based services	MMIS MMIS

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
Long-Term Care (LTC) Reform **(SECTION 4.1)**			**LTC 4.1.3.2**- How many LTC applicants who meet the new financial eligibility thresholds remain in home- or community-based settings rather than enter an LTC facility?		
	LTC 4. 2- To establish objective, needs-based level of care determinations for Medicaid long-term care applicants and beneficiaries	**LTC 4.2.1**- To develop systems for the delivery of needs-based level of care determinations for Medicaid LTC applicants and beneficiaries, focused upon identifying applicants' medical, behavioral and social needs which could impact their ability to remain safely in home- and community-based settings	**LTC 4.2.1.1-** How many new LTC applicants meet the State's level of care categories: highest, high, and preventive? How many new Medicaid LTC applicants do not meet any of these three levels of care?		MMIS
			LTC 4.2.1.2- How many new Medicaid LTC applicants whose level of care needs were classified in the highest category received home- and community based services?		MMIS
			LTC 4.2.1.3- How many of the State's current (enrolled prior to 7/1/09) LTC beneficiaries whose level of care needs were classified in the highest category at the time of eligibility redetermination received	Number of clients who were approved to receive preventive level services	MMIS

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
Long-Term Care (LTC) Reform **(SECTION 4.1)**			home- and community-based services and how many received care in LTC facilities?	Medicaid-Paid Home and Community Based Preventive Services Utilization	
			LTC 4.2.1.4-Over the course of the 1115 Waiver, how many new Medicaid LTC applicants whose level of care needs were classified as meeting the preventive level of care criteria received preventive-level services?		Communications Files
			LTC 4.2.1.5- Over the course of the 1115 Waiver, has there been a change in utilization of preventive care services?	Quantify the number and types of selective contracting arrangements	Communications Files
	LTC 4.3- To limit the rate of growth of the State's Medicaid expenditures	**LTC 4.3.1**- To control expenditure growth by implementing the above objectives	**LTC 4.3.1.1**- Have the overall costs of providing Medicaid-covered services to population groups eligible prior to the implementation of the 1115 Waiver been controlled?		MMIS
		LTC 4.3.2- To implement selective contracting based upon Rhode Island's purchasing analyses	**LTC 4.3.2.1-** Over the course of the 1115 Waiver, how many selective contracting strategies were initiated by the State? How many contractors were	Medicaid Expenditures for Aged and Disabled Beneficiaries in Home and Community-Based Care	MMIS

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
Long-Term Care (LTC) Reform **(SECTION 4.1)**			engaged to provide services? **LTC 4.3.2.2-** Over the course of the 1115 Waiver, has there been a change in utilization of services covered by selective contracting arrangements?	Medicaid Expenditures for Aged and Disabled Beneficiaries in Institutional Care	
			LTC 4.3.2.3- Over the course of the 1115 Waiver, have the selective contracting strategies resulted in controlled Medicaid expenditures for the related services? Refer to Section 4.5- Focused Evaluations of Expansion Groups	Medicaid-Paid Home and Community Based Preventive Services Utilization	MMIS
		LTC 4.3.3- To prevent or delay growth in Medicaid eligibility for full benefits by instituting Medicaid claiming for selected populations and/or services using costs not otherwise matchable (CNOM) authority	Regarding **4.3.3**: Please refer to Section 4.5 for CNOM discussion	Enrollment as of the End of the Reporting Period	MMIS

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
Long-Term Care (LTC) Reform **(SECTION 4.1)**		**LTC 4.3.4**-To promote the delivery of case management services for beneficiaries through organized systems of care.	**LTC 4.3.4.1**- Over the course of the 1115 Waiver, how many beneficiaries and what proportion were enrolled in the following organized care management delivery systems: Connect Care Choice and Rhody Health Partners **LTC 4.3.4.2-** Over the course of the 1115 Waiver, how many beneficiaries without another source of health insurance remained in Medicaid fee-for-service?	FFS Enrollment as of the End of the Reporting Period	

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
RIte Care[1] **(SECTION 4.2)**	**RC 4.2 A**- To increase access to and improve the quality of care for Medicaid families eligible for the demonstration **RC 4.2 B**- To expand access to health coverage to all eligible pregnant women and all eligible uninsured children and adults To control the rate of growth in the Medicaid budget for the eligible population[3]	**RC 4.2.1**- To reduce uninsurance in the expansion population groups eligible for the Demonstration **RC 4.2.2**- To provide all enrollees in the Demonstration with a *medical home*	**RC 4.2.1.1**- Will the rate of uninsurance in the expansion population groups eligible for the Demonstration be reduced as a result of this Demonstration? **RC 4.2.2.1**- Will all enrollees in the Demonstration have a *medical home*? **RC 4.2.2.2**- Will access to health care for populations eligible for the Demonstration be improved? **RC 4.2.2.3**- Will the appropriate use of inpatient hospitals and hospital emergency departments increase? **RC 4.2.2.4**- Will the rate of infant mortality in the State be reduced during the course of this Demonstration? **RC 4.2.2.5**- Will maternal and child health outcomes	Rate of uninsurance in the State Enrollment as of the End of the Reporting Period Utilization Cost-Sharing Complaints, Grievances and Appeals	Current Population Survey MMIS Encounter Data System MMIS Health Plan-specific reports submitted to DHS CAPHS®

[1] Separate evaluation design submitted to CMS on August 26, 2008.

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
RIte Care[2] **(SECTION 4.2)**		**RC 4.2.3**-To improve access to health care for populations eligible for the Demonstration **RC 4.2.4**- To increase the appropriate use of inpatient hospitals and hospital emergency departments **RC 4.2.5**- To reduce infant mortality **RC 4.2.6**- To improve maternal and child health outcomes **RC 4.2.7**- To have a high satisfaction level with the demonstration project among enrolled populations	for populations enrolled in the Demonstration improve? **RC 4.2.2.6**- Will populations enrolled in the Demonstration have a high level of satisfaction with the Demonstration project?	Member Satisfaction	

[3] This was a separate goal for RIte Care when it was a stand-alone Demonstration. Since there will not be a separate budget neutrality test for RIte Care/RIte Share under the 1115 Waiver, separate evaluation against this goal will be dropped.

[2] Separate evaluation design submitted to CMS on August 26, 2008.

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
RIte Share **(SECTION 4.3)**	**RS 4.3-** To expand access to health coverage to all eligible pregnant women and all eligible uninsured children and adults	To provide a cost-effective alternative to Medicaid eligibility through mandatory participation in employer-sponsored insurance (ESI)	**RS 4.3.1-** Will Medicaid-eligible individuals avail themselves of ESI? **RS 4.3.2-** Will a premium subsidy program be cost-effective?	Enrollment as of End of Reporting Period Gross and Net Savings	MMIS MMIS
Extended Family Planning Program[4] **(SECTION 4.4)**	**EFP 4.4-** To control the rate of growth in the Medicaid budget for the eligible population	**EFP 4.4.1-** To avert future Medicaid-funded births by providing family planning services to Medicaid-eligible women who lost their Medicaid-eligibility 60 days post-partum **EFP 4.4.2-** To increase the inter-birth spacing for Medicaid-funded births by providing family planning services to Medicaid-eligible women who lost their Medicaid-eligibility 60 days post-partum	Will the rate of Medicaid-funded births for women eligible for the Demonstration decrease? Will the percentage of Medicaid-funded births with short inter-birth intervals decrease?	Enrollment as of End of Reporting Period Births per 1,000 women aged 15-44 enrolled in the Demonstration Percent of women on Medicaid waiting at least 18 months between births Family planning patient receiving a clinical referral for primary care	MMIS Encounter Data System Vital Statistics Birth File Survey

[4] Separate evaluation design submitted to CMS on August 28, 2008. See Appendix B for more detail.

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
FOCUSED EVALUATIONS					
Children and families in managed care and continued eligibility for RIte Care parents when kids are in temporary state custody **(SECTION 4.5 - Budget Population 8)**	Same as RIte Care	Same as RIte Care	Same as RIte Care	Same as RIte Care	Same as RIte Care

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
Children with special health care needs (as an eligibility factor) who are under 21 who would otherwise be placed in voluntary State custody – residential diversion **(SECTION 4.5 – Budget Population 9 & Budget Services Group 4)**	To provide a limited benefit package for children with special health care needs (CSHCN) who have not been voluntarily placed in State custody, thereby allowing them to function in the least restrictive environment.	**CNOM 4.5-2:** To provide a cost-effective, home- and community-based alternative to institutional care for CSHCN.	**CNOM 4.5-2-1:** Over the course of the 1115 Waiver, has the utilization of home- and community-based services prevented or delayed the placement of CSHCN in a LTC facility? **CNOM 4.5-2-2:** Will a month of home- and community-based services cost less than the projected monthly cost of a stay in a LTC facility for Budget Population 9 & Budget Services Group 4?	Number of clients who were approved to receive home- and community-based services Number of clients receiving more than one or more home- and community-based services Number of times client receiving services entered LTC Facility Total cost of care plan as compared to monthly cost for LTC facility care	MMIS

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
Elders 65 and over **(SECTION 4.5- Budget Population 10)**	To assist elders over the age of 65 to maintain optimum health and functioning in the least restrictive environment by providing home- and community based services to qualified beneficiaries.	To improve client stability and functioning in the community To provide a cost-effective alternative to institutional care	**CNOM 4.5.3.1**- Over the course of the 1115 Waiver, how many applicants were approved to receive the designated home- and community-based services available to Budget Population 10? **CNOM 4.5.3.2**- Over the course of the 1115 Waiver, has there been a change in the utilization of core home- and community-based services by individuals approved for Budget Population 10's benefit package? **CNOM 4.5.3.3**- Over the course of the 1115 Waiver, will the utilization of services to prevent or delay placement in a LTC facility for at least six (6) months? **CNOM 4.5.4.1**- Will a month of home care services cost less than the monthly cost of a LTC facility?	Number of clients who were approved to receive home- and community-based services Number of clients receiving more than one or more home- and community-based services Number of times client receiving services entered LTC Facility Total cost of care plan as compared to monthly cost for LTC facility care	Claims Data DEA Service Data Case Record Review Claims Data Client Satisfaction Survey Case Record Review Claims Data

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
Adults with disabilities served by the Office of Rehabilitative Services who are not eligible for Medicaid, but who may become so if these services are not provided **(Section 4.5 – Budget Population 15)**	To provide a limited benefit program for adults with disabilities who are at risk for long-term care (LTC), thereby promoting their ability to function in the least restrictive environment.	**CNOM 4.5-5:** To increase adults with disabilities' access to a designated set of home- and community-based services. **CNOM 4.5-6:** To provide a cost-effective, home- and community-based alternative to institutional care for adults with disabilities.	**CNOM 4.5.5.1:** Over the course of the 1115 Waiver, how many applicants were approved to receive the designated set of home- and community-based services available to Budget Population 15? **CNOM 4.5.5.2:** Over the course of the 1115 Waiver, has there been a change in the utilization of home- and community-based services by adults with disabilities who have been approved to receive Budget Population 15's limited benefit program? **CNOM 4.5.6.1:** Over the course of the 1115 Waiver, has the utilization of home- and community-based services prevented or delayed the placement of adults with disabilities in a LTC facility? **CNOM 4.5.6.2**: Will a month of home- and community-based	Number of clients who were approved to receive home- and community-based services Number of clients receiving more than one or more home- and community-based services Number of times client receiving services entered LTC Facility Total cost of care plan as compared to monthly cost for LTC facility care	MMIS

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
			services cost less than the projected monthly cost of a stay in a LTC facility for Budget Population 15?		
Uninsured adults with Mental Illness/Substance Abuse (MI/SA) problems **(SECTION 4.5- Budget Population 16)**	To provide cost-effective services that will ensure recipients receive the appropriate services in the least restrictive and most appropriate setting	**CNOM 4.5.7**- To increase access for uninsured adults with mental illness and/or substance abuse problems to a designated set of community-based services	**CNOM 4.5.7.1-** Over the course of the 1115 Waiver, how many uninsured adults with MI/SA problems who applied were approved to receive the designated community-based services available to Budget Population 16? **CNOM 4.5.7.2**- Over the course of the 1115 Waiver, has there been a change in the utilization of community-based MI/SA treatment services by uninsured adults who were approved to participate in Budget Population 16?	Number of clients who were approved to receive community-based services Number of clients receiving more than one or more and community-based services Medicaid-paid community-based MI/SA utilization	MMIS MMIS MMIS MMIS
		CNOM 4.5.8- To reduce the number of Medicaid-paid psychiatric inpatient admissions and inpatient admissions for drug/alcohol detoxification	**CNOM 4.5.8.1**- Over the course of the 1115 Waiver, will there be a reduction in the number of Medicaid-paid psychiatric hospitalizations or	Admissions for Psychiatric Hospitalization or Detoxification/1,000 Member-Months Psychiatric Hospital Days or	MMIS

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
Uninsured adults with Mental Illness/Substance Abuse (MI/SA) problems **(SECTION 4.5-Budget Population 16)**		**CNOM 4.5.9**- To reduce the average inpatient MI/SA length of stay (ALOS) **CNOM 4.5.10**- To reduce inpatient readmissions within 30 days of MI/SA hospital discharges	inpatient detoxification? **CNOM 4.5.9.1**- Will there be a reduction in inpatient MI/SA ALOS over the course of the 1115 Waiver? **CNOM 4.5.10.1**- Will there be a reduction in inpatient readmissions within 30 days of MI/SA hospital discharges?	Detoxification/1,000 Member-Months Admissions for Psychiatric Hospitalization or Detoxification/1,000 Member-Months Medicaid-Paid Institutional Care Days Readmission Rate for Psychiatric Hospitalization within 30 Days of Discharge	MMIS MMIS
Coverage of detection and intervention services for at-risk young children **(SECTION 4.5-Budget Population 17)**	To provide a limited benefit package for children less than 18 years of age who are at risk of institutional care, thereby allowing these children to function in the least restrictive environment	**CNOM 4.5.11**- To increase access for children at risk of requiring institutional care who are not Medicaid eligible to a designated set of home- and community-based services available to Budget Population 17 To provide a cost-effective , home- and community-based alternative to institutional care for children less than 18 years of age who are at	**CNOM 4.5.11.1**- Over the course of the 1115 Waiver, how many applicants (children less than 18 years of age who are at risk of institutional care) were approved to receive the designated home- and community-based services available to Budget Population 17? **CNOM 4.5.11.2**- Over the course of the 1115 Waiver, has there been a change in the utilization of home- and community-	Number of clients who were approved to receive home- and community-based Number of clients receiving more than one or more home- and community-based services Utilization of home- and community-based services	MMIS MMIS MMIS

Waiver Area	Goals	Objectives	Evaluation Questions	Illustrative Measures	Data Source(s)
		risk of institutional care	based services by children under 18 years of age who were approved to participate in Budget Population 17's limited benefit program?		
HIV services **(SECTION 4.5-Budget Population 18)**	Under Development	Under Development	Under Development	Under Development	Under Development
Administrative process flexibility	To implement changes to Medicaid program more expeditiously	To implement changes to the Medicaid program within STC-specified timeframes	Are changes approved within the timelines specified in the STCs for each category of change?	Days from the date of submission to CMS approval for Category 2 and Category 3 Changes	Communications Files