

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850



DEC 20 2018

Patrick Tighe
Deputy Secretary for Medical Assistance
Rhode Island Department of Health and Human Services
2001 Mail Service Center
Raleigh, RI 27699-2001

Dear Mr. Tighe:

This letter is to inform you the Centers for Medicare & Medicaid Services (CMS) is approving Rhode Island's (the state) request to extend the section 1115 Medicaid demonstration project, entitled "Rhode Island Comprehensive Demonstration" (Project Number 11-W-00242/1) in accordance with section 1115(a) of the Social Security Act (the Act), along with the state's request for approval of modifications of the demonstration going forward.

This approval is effective January 1, 2019 through December 31, 2023. CMS's approval is subject to the limitations specified in the attached waiver authorities, expenditure authorities, Special Terms and Conditions (STCs), and subsequent attachments. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been listed as waived or as not applicable to expenditures or individuals covered by expenditure authority.

Objectives of the Medicaid Program

Under section 1901 of the Act, the Medicaid program provides federal funding to participating states "[f]or the purpose of enabling each state, as far as practicable under the conditions in such state, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."

As this statutory text makes clear, a basic objective of Medicaid is to enable states to "furnish... medical assistance" to certain vulnerable populations (i.e., payment for certain healthcare services defined at section 1905 of the Act, the services themselves, or both). By paying these costs, the Medicaid program helps vulnerable populations afford the medical care and services they need to attain and maintain health and well-being. In addition, the Medicaid program is

supposed to enable states to furnish rehabilitation and other services to vulnerable populations to help them “attain or retain capability for independence or self-care,” per section 1901 of the Act.

We are committed to supporting states that seek to test policies that are likely to improve beneficiary health, because we believe that promoting independence and improving health outcomes is in the best interests of the beneficiary and advances the fundamental objectives of the Medicaid program. Healthier, more engaged beneficiaries may also consume fewer medical services and have a lower risk profile, making the program more sustainable. Policies designed to improve beneficiary health that lower program costs make it more practicable for states to make improvements and investments in their Medicaid program and ensure the program’s sustainability so it is available to those who need it most. In so doing, these policies can promote the objectives of the Medicaid statute.

While CMS believes that states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations, the agency has an obligation to ensure that proposed demonstration projects are likely to promote the objectives of the Medicaid statute, including through measures designed to improve health and wellness and help individuals and families attain or retain capability for independence or self-care. Medicaid programs are complex and shaped by a diverse set of interconnected policies and components, including eligibility standards, benefit designs, reimbursement and payment policies, information technology (IT) systems, and more. Therefore, in making this determination, CMS considers the proposed demonstration as a whole.

Extent and Scope of the Demonstration

Rhode Island operates its entire Medicaid program under its existing Comprehensive Demonstration, with the exception of: 1) disproportionate share hospital (DSH) payments; 2) administrative expenses; 3) phased-Part D contributions; and 4) payments to local education agencies (LEA) for services that are furnished only in a school-based setting, and for which there is no third-party payer. With those four exceptions, all Medicaid-funded services on the continuum of care from preventive care in the home and community to care in high-intensity hospital settings to long-term and end-of life-care whether furnished under the approved state plan, or in accordance with waivers or expenditure authorities granted under this demonstration are subject to the requirements of the demonstration.

In October 2016, CMS approved an amendment for the state to develop the Health System Transformation Project (HSTP) to create shared savings agreements between managed care organization (MCO) health plans and certified Accountable Entities (AEs) through value-based contracts. The AEs are responsible for improving the quality of care, and there will be alternative payment models established, between MCOs and AEs through the development of value-based contracts.

On July 11, 2018, Rhode Island submitted an application for a five-year renewal of its current section 1115 demonstration “Rhode Island Comprehensive Demonstration,” along with approval of modifications of the demonstration that would apply during the extension period. The

purpose of the state’s proposal is to support the continuation of Rhode Island’s Medicaid program and to add new programs discussed below.

The state will continue its home and community-based services (HCBS) component to provide services similar to those authorized under sections 1915(c) and 1915(i) of the Act to individuals who need HCBS either as an alternative to institutionalization or otherwise based on medical need. Effective January 1, 2019, the existing services will continue under the demonstration and be obligated to adhere to HCBS guidelines, policies, and reporting procedures. Any new HCBS requests the state would like to implement after January 1, 2019, will be authorized under sections 1915(c) and 1915(i).

In addition, this approval authorizes the state to receive federal financial participation (FFP) for the continuum of services to treat addictions to opioids and other substances, including services provided to Medicaid enrollees with a substance use disorder (SUD) who are short-term residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD).

Determination that the Demonstration Project is Likely to Assist in Promoting Medicaid’s Objectives

In its consideration of Rhode Island’s section 1115 demonstration proposal, CMS examined whether the demonstration was likely to assist in improving health outcomes, addressing health determinants that influence health outcomes, incentivizing beneficiaries to engage in their own health care and achieve better health outcomes, and better enabling Rhode Island, “as far as practicable under the conditions in” the state, to furnish medical assistance, per section 1901 of the Act. CMS has determined the Rhode Island Comprehensive Medicaid 1115 Demonstration is likely to promote Medicaid objectives, and the waiver and expenditure authorities sought are necessary and appropriate to carry out the demonstration. The following discusses individual aspects of the overall demonstration and how they are likely to promote the objectives of the Medicaid program.

(1) Expenditure Authority to Cover Treatment in a Psychiatric Residential Treatment Facility (PRTF) for Certain Children with Serious Emotional Disturbance (SED) Not Otherwise Eligible for Medicaid or CHIP

CMS is approving expenditure authority to allow children who are not otherwise eligible for Medicaid or CHIP, with a diagnosis of serious emotional disturbance (SED), who meet the supplemental security income (SSI) disability criteria, and are in need of long-term placement in a residential facility, to be considered a family of one to be Medicaid-eligible for the services in a psychiatric residential treatment facility (PRTF). Currently, parents in Rhode Island whose household income and assets exceed SSI resource limits must relinquish custody to the Department of Children and Families for the child to be eligible for Medicaid and receive treatment in a PRTF. The goal of this expenditure authority is to avoid having parents relinquish custody of their children to the state in order to access Medicaid coverage and receive needed treatment.

(2) Establishment of the Family Home Visiting Services Program to Improve Birth and Early Childhood Outcomes

Rhode Island will implement the Family Home Visiting Services Program under this demonstration to increase the number of people who can access the home visiting programs developed by the Healthy Families America and Nurse Family Partnership, which focus on prenatal care, post-partum care, and early childhood development. Implementation of this program is projected to increase the likelihood of healthy pregnancies and improve birth outcomes, improve the health and development of children, increase school readiness and parental involvement in the child's care and education, and increase financial self-sufficiency for families.

(3) Expansion of Peer Support Services

CMS is approving the state's requests to expand its peer support services model that previously served only adults with substance use disorders to include children and youth identified with serious emotional disturbances and their parents and/or caretakers. Peer support is an important component of support to enhance positive outcomes for children and youth while addressing mental and behavioral health issues. Peer support programs also provide parents and caregivers the opportunity to connect with and support each other to reduce stress, improve mental health and well-being, increase self-efficacy, and increase treatment engagement. Expansion of peer support services in the demonstration to include children and youth is likely to improve health outcomes for Medicaid beneficiaries who participate and is expected to help beneficiaries receive the appropriate care for their specific needs.

(4) Development of Home-Based Primary Care Services

CMS is approving the state's request to develop a program that will offer primary care services in the beneficiary's home who are homebound or have functional limitations that make it difficult to access primary care, or for whom routine office based primary care is not effective because of complex, medical, social, and/or behavioral health conditions. CMS expects that home-based primary care services will offer a cost-effective solution to make sure patients receive necessary care for the whole person, and research shows these services reduce hospitalizations and improve a person's quality of care. CMS expects that this program will promote the objectives of Medicaid by enhancing access to care and providing higher quality, cost-effective care for homebound and medically frail Medicaid populations.

(5) Behavioral Health Link (BH Link) Program

Through this demonstration, the state will develop the Behavioral Health Link Program (BH Link), a triage center for beneficiaries experiencing a behavioral health crisis. The BH Link will begin as one triage center to support crisis stabilization and short-term treatment for beneficiaries experiencing a behavioral health (mental health and/or substance use disorder) crisis. This triage center will provide access to specialized emergency behavioral healthcare services in settings other than in emergency departments. The BH Link triage center will

provide screening/evaluations, treatment, crisis intervention—including local mobile outreach, case management, peer support, assessment, treatment coordination, 23-hour observation beds, discharge planning, warm hand-offs to community providers, and medications. The BH Link program is expected to enhance the state’s community-based crisis stabilization, allowing behavioral health experts to meet the mental and behavioral health needs of beneficiaries in a less restrictive hospital setting. Adding this program to the demonstration is expected to help beneficiaries receive the appropriate care for their specific needs.

(6) Dental Case Management Pilot

The state will develop an oral health pilot that will focus on using four new dental case management service codes to emphasize health care coordination, improve oral health literacy, and support patient compliance among participating Medicaid beneficiaries. Up to six (6) dental practices will be able to bill and be reimbursed for four (4) new dental case management Current Dental Terminology codes. This pilot may improve health outcomes for participating beneficiaries as it may improve oral health for them, and improving oral health may positively impact overall physical health.

(7) Substance Use Disorder (SUD) Program

Approving the SUD program is expected to allow the state to better address opioid use disorders and other SUDs, which are a serious public health concern in Rhode Island. The SUD program will improve access to high-quality addiction-related services and is critical to addressing Rhode Island’s substance use epidemic. Under this program, all Medicaid beneficiaries will continue to have access to all current mental health and SUD benefits. In addition, this approval authorizes the state to receive federal financial participation (FFP) for the continuum of services to treat addictions to opioids and other substances, including services provided to Medicaid enrollees with SUD who are short-term residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD).

Rhode Island also submitted its SUD Implementation Plan as required by the STCs. CMS has completed its review of the SUD Implementation Plan and determined that it is consistent with the requirements set forth in the STCs and is, therefore, concurrently approving it as an attachment to the STCs. With this concurrent approval, the state may begin receiving FFP under the terms of the demonstration, effective as of January 1, 2019.

(8) Reauthorization of the Waiver of Retroactive Eligibility

The state has requested and we are allowing Rhode Island to maintain its long-standing retroactive eligibility waiver. The state has had this waiver since the 1990s. This waiver of retroactive eligibility does not apply to individuals under 1902(l)(4)(A) of the Act, or the Aged, Blind, and Disabled (ABD) population.

As part of this demonstration, Rhode Island will test whether this policy encourages Medicaid beneficiaries to obtain and maintain health coverage, even when healthy, or to obtain health

coverage as soon as possible after becoming eligible (e.g., if eligibility depends on a finding of disability or a certain diagnosis). The state will evaluate whether the policy increases continuity of care by reducing gaps in coverage that can occur when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick, and facilitates receipt of preventive services when beneficiaries are healthy. In circumstances where Medicaid eligibility depends upon a finding of disability or a certain diagnosis (e.g., of breast or cervical cancer), the state will evaluate whether the policy encourages beneficiaries to apply for Medicaid as soon as possible after the relevant finding or diagnosis. By continuing the waiver of retroactive eligibility for Rhode Island Medicaid beneficiaries, the demonstration will test the efficacy of measures that are designed to encourage eligible individuals to enroll as soon as possible, and, for certain populations, that are designed to encourage eligible individuals to maintain health coverage even while healthy. This feature of the demonstration is designed to encourage enrollment as soon as possible, to facilitate receipt of preventive care and other needed services, with the ultimate objective of improving beneficiary health.

(9) Continuation of October 2016 Approved Funding for the Health System Transformation Program (HSTP)

In October 2016, CMS approved five years of Designated State Health Program (DSHP) funding for Rhode Island to support the HSTP. In this demonstration renewal, CMS is approving the final two years of DSHP to continue its commitment in the October 2016 approval letter that “CMS is approving expenditure authority for DSHP of \$129.7 million over five years, contingent upon successful implementation of the demonstration.” The DSHP is only allowed for CY 2019 and CY 2020, for a total amount of \$49.8 million (total computable). This is consistent with the approach CMS articulated in a December 2017 State Medicaid Director (SMD) Letter (SMD #17-005), indicating CMS’s intention to allow states with existing DSHP to continue to the end of the approved period, and to cease approval of new DSHP.

Elements of the Demonstration Request CMS is Not Approving at This Time

In the state’s demonstration extension application, the state requested certain additional flexibilities that CMS is not approving at this time. CMS intends to continue discussing these flexibilities with the state, which include:

- 1) Telephonic psychiatric consultation when the beneficiary is not present;
- 2) Additional HCBS during the presumptive eligibility period;
- 3) Additional HCBS to address social determinants of health; and
- 4) SMI IMD expenditure authority.

Consideration of Public Comments

CMS and the state received numerous comments throughout the federal and state comment periods. Consistent with federal transparency requirements, CMS reviewed all of the received public comments along with the summarized public comments submitted by the state, when evaluating whether the demonstration and the proposed projects were likely to promote the objectives of the Medicaid program, and whether the waiver and expenditure authorities sought were necessary and appropriate to implement the demonstration. In addition, public

comments were considered in the development of the STCs that accompany this approval.

CMS received several comments in support of the many aspects of the demonstration renewal. Many supporters of the demonstration renewal were receptive to the state's increased investment in services that facilitate patient-centered, community-based, recovery-oriented, coordinated care, which will help avoid high-cost hospitalizations. Comments included that through recent research, the state is making efforts to increase investments in proven effective preventive services, and family supports improve outcomes for children, youth, and families, therefore reducing the need for more intensive services. CMS appreciates the commenters that support the demonstration renewal.

Some comments focusing on the behavioral health framework within the renewal were found to have support, while some comments expressed concerns from the community. Public comments received thought that Rhode Island's renewal demonstration was developed to strengthen and improve the state's behavioral health treatment framework and reduce avoidable hospital admissions, but the path to develop the framework raised both praise and concerns. Some commenters raised concerns with the state's request to for expenditure authority for services provided in Institutions for Mental Diseases (IMD), including for beneficiaries residing in the IMD for non-ODU/SUD services. The commenters raised concerns that the state does not currently have a sufficient level of mental health community services. For example, the commenter shared concerns that the state does not have any Assertive Community Treatment (ACT) teams. If there were more ACT available, then more people could be served in the community and not in an IMD. At this time, CMS is not approving the state's request for expenditure authority for services delivered in an IMD for beneficiaries who are residing in the IMD primarily to receive mental health treatment. CMS and the state are continuing to work on the state's request and will take these comments into consideration.

The development of the BH Link triage center was commended as a part of the state's improvement of its behavioral health system. One commenter supported the state's intention to provide the new services; however, the commenter urged the state Medicaid agency to consider the time, patient level of complexity, and practice expenses needed to provide these new services. CMS shared these recommendations with the state, and it is taking this under advisement in its approach to patient care and practice operations. CMS will work with the state to assure Medicaid payment requirements are met.

Comments also supported Rhode Island's application to request expenditure authority to provide SUD services to individuals who are short-term residents in residential treatment facilities that meet the definition of an IMD. Through this request, supporters commented that the state was making an effort to enhance the behavioral health framework within the state by allowing providers in IMDs to deliver services consistent with the most recent edition of the American Society of Addiction Medicine (ASAM) criteria and provide evidence-based substance use and opioid use disorder treatment. Some comments recommended that CMS and the state ensure that treatment provider assessments for all addiction treatment services, levels of care, and length-of-stay recommendations, as well as residential treatment provider qualifications, are performed by an independent third-party that has the necessary competencies to use the most recent edition of

the ASAM criteria or such other evidence-based patient placement assessment tools and nationally-recognized program standards. CMS appreciates these comments, and notes that the STCs require that the state not only submit a SUD Implementation Plan, but that the SUD Implementation Plan reflects key goals and milestones, including but not limited to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities. CMS has developed a rigorous SUD monitoring plan to evaluate the state's progress of the initiative towards specific milestones including:

- Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)
- Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)
- Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)
- Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)
- Improved Care Coordination and Transitions between Levels of Care (Milestone 6).

The demonstration is expected to increase access to critical levels of care for OUD and other SUD, increase the use of evidence-based, SUD-specific patient placement criteria, and to set standards for residential treatment provider qualifications across the state. The IMD expenditure authority will allow some larger SUD residential treatment providers to assist the state in alleviating some of the access challenges that Rhode Island faces for these particular levels of care (ASAM III.1 – III.5). Through this renewal, the state requested to expand its peer support model which currently serves only adults with substance use disorders, to include children and youth, identified with serious emotional disturbances and their parents and/or caretakers. The BH Link program will support the state's community-based crisis stabilization, allowing behavioral health experts to meet the mental and behavioral health needs of beneficiaries in a less restrictive hospital setting. This program will also provide local mobile outreach, case management, treatment coordination, discharge planning, and warm hand-offs to community providers for continued success towards behavioral health and substance use disorders.

The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. Your project officer for this demonstration is Mrs. Heather Ross. She is available to answer any questions concerning your demonstration project. Mrs. Ross' contact information is as follows:

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Telephone: (410) 786-3666
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Official communications regarding this demonstration should be sent simultaneously to Mrs. Ross and Mr. Richard McGreal, Associate Regional Administrator (ARA) in our Boston

Regional Office. Mr. McGreal's contact information is as follows:

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If you have any questions regarding this approval, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid & CHIP Services at (410) 786-9686.

Sincerely,



Mary C. Mayhew
Deputy Administrator and Director

cc: Richard McGreal, Associate Regional Administrator, CMS Boston Region