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

The Rhode Island 1115 Waiver Extension Request

Proposed Draft as of March 23, 2018

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Section 1. Program Description

1.1. Introduction

The State of Rhode Island (RI) seeks federal approval to extend its Medicaid Section 1115 demonstration waiver (hereinafter the *Demonstration*).

Medicaid is essential to the fabric of the state's health care system covering a large swath of the state's population. It serves nearly one-third of the state's population and constitutes the largest component of the state's annual budget: General Revenue expenditures for the program alone are expected to reach $2.9 billion in State Fiscal Year (SFY) 2018.

The state's investment in Medicaid has produced important tangible results. It is lauded nationwide for the success of its RIte Care managed care delivery system, efforts to promote healthy outcomes for high-risk populations, and continued emphasis on value-based purchasing and payment reform. It has also contributed to significant reductions in the state's uninsured rate – from 11.6% (120,000) in 2013 to 4.3% (45,000) in 2016 – which is now among the lowest in the country.[1]

Over the past waiver period, the Rhode Island Medicaid program, administered by the Rhode Island Executive Office of Health and Human Services (EOHHS), has implemented significant changes aimed at improving health care quality and outcomes to bend the cost curve. EOHHS intends to sustain these efforts and continue on the path to reforming health care delivery in the state that was charted under the current Demonstration. Accordingly, this Demonstration renewal focuses on improving and strengthening the services and processes that are already in place to allow the state to better serve its Medicaid beneficiaries.

1.2. History of the Rhode Island Section 1115 Demonstration Waiver

CMS initially approved the RI Demonstration in 2009 as the Global Consumer Choice Compact Waiver (Global Waiver). At the time, RI's waiver was unique in the nation for its scope (all Medicaid populations were included), and the flexibility afforded to the state in exchange for operating the program under a fixed, aggregate spending cap.

When the state requested the first Demonstration extension in 2013, the Patient Protection and Affordable Care Act (ACA) of 2010's enactment had significantly changed the health care landscape across the country. In addition to authorizing and financing certain coverage expansions, the ACA created new opportunities and challenges for the EOHHS Medicaid program. The Demonstration extension request approved on December 23, 2013 reflected the state's response to these changing realities.

Rhode Island was one of a handful of states to exercise the ACA option to build its own unified health insurance exchange to determine eligibility for Medicaid and exchange coverage. To

[1] Barnett, J.C. & Edward, B.R. (2017). Health insurance coverage in the United States: 2016. U.S Census Bureau, U.S. Department of Commerce. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf

maximize access to affordable coverage, the state extended Medicaid eligibility under the state plan to cover ACA expansion (childless) adults and created a new premium subsidy program for parents/caretakers with incomes between 133% and 175% of the Federal Poverty level (FPL) who were moved from Medicaid coverage into the state's health insurance exchange, HealthSource RI. The Demonstration extension redefined the MAGI-related budget populations and associated funding authorities (i.e., State Plan, CHIP, waiver) accordingly, and eliminated services funded as costs not otherwise matchable (CNOM) under the original waiver for those eligible for full benefits under the State Plan through the ACA expansion.

The initial Demonstration extension request was decidedly focused on reorienting waiver authorities to support ACA-related initiatives. However, The ACA's eligibility changes and maintenance of effort requirements brought considerable fiscal uncertainty to the state, and limited its ability to exercise the Demonstration's existing authorities and flexibilities to institute additional program changes. As such, the state proposed to drop the aggregate cap in favor of a more traditional Section 1115 financing scheme, and change the Demonstration's title accordingly to: *The Rhode Island Medicaid Section 1115 Comprehensive Demonstration Waiver*.

Despite the shift in the financing arrangements, RI remained committed to achieving many of the central goals of the Global Consumer Choice Waiver, particularly with respect to long-term care rebalancing, universal care management, and value-based purchasing. Accordingly, RI sought to retain these authorities and, in some cases expand them further, with a focus on moving towards a population health approach to care delivery and implementing more efficient, performance-based purchasing strategies.

1.3. Rhode Island's Vision for Medicaid

Over the last three years, Rhode Island has undertaken a comprehensive strategic process to ensure that the Medicaid program effectively serves its beneficiaries while being a good steward of the state and federal dollars used to finance it. This effort began with an Executive Order signed by Governor Gina Raimondo in February 2015 to establish the Working Group to Reinvent Medicaid. This Working Group was charged with identifying progressive, sustainable savings initiatives to transform the state's Medicaid program into one that pays for better outcomes, better coordination, and higher-quality care.

The Working Group included partners from the health care sector, the advocacy community, the business community at large, and the RI Executive Office of Health and Human Services. With strong support from the General Assembly and community leaders, RI passed the Reinventing Medicaid Act of 2015, positioning EOHHS to expand and improve access to quality care and reducing costs. This sweeping overhaul of the program reduced annual General Revenue spending on Medicaid by $100 million while maintaining eligibility and benefits.

The Working Group submitted its final report in July 2015 which outlined a plan for a multi-year transformation of the Medicaid program and all state publicly financed health care in Rhode Island. The report established the principles and goals outlined in Table 1.1 for the Medicaid program. These principles and goals were designed to orient the program towards delivering high-quality, high-value care, and continue to guide the Medicaid program today.

Table 1.1: Key Principles and Goals of the Rhode Island Medicaid Program

Principles	Goals
Principle 1: Pay for value, not for volume	• **Goal 1:** Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes and total cost of care for their members. • **Goal 2:** Define Medicaid-wide population health targets, and, where possible, tie them to payments. • **Goal 3:** Maintain and expand on our record of excellence -including our #1 ranking -on delivering care to children.
Principle 2: Coordinate physical, behavioral, and long-term health care	• **Goal 4:** Maximize enrollment in integrated care delivery systems • **Goal 5:** Implement coordinated, accountable care for high-cost/high-need populations • **Goal 6**: Ensure access to high-quality primary care • **Goal 7:** Leverage health information systems to ensure quality, coordinated care
Principle 3: Rebalance the delivery system away from high-cost settings	• **Goal 8:** Shift Medicaid expenditures from high-cost institutional settings to community-based settings • **Goal 9**: Encourage the development of accountable entities for integrated long-term care
Principle 4: Promote efficiency, transparency, and flexibility	• **Goal 10:** Improve operational efficiency

With these principles and goals in mind, the state set out to transform the Medicaid program to a system that that is more consciously and effectively organized towards achieving the Triple Aim of controlling costs, while improving health and the experience of care.

To support these efforts RI sought and received CMS approval for the Health System Transformation Project (HSTP). The HSTP gave RI expenditure authority of up to $129.7 million over five years for designated state health programs (DSHPs) that promote healthcare workforce development and support the establishment of accountable entities (AEs) through Medicaid managed care contracts. The key components of RI's Health System Transformation Project include:

- **Encouraging accountability at the provider level.** This means establishment of integrated provider organizations – accountable entities – that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population.

- **Developing the next generation managed care.** RI's strong managed care program and its multi-year investment in an effective managed care oversight structure makes managed care the optimal vehicle for the move towards accountable care. This means a re-

engineering of the managed care contracts, and a deliberate and focused effort to maximize the members and services included in managed care contracts.

- **Building a robust health care workforce.** Integrating primary care and behavioral health providers with clinical care management teams and community health workers within the accountable entity is a critical component to successful management of complex populations. This workforce needs to be developed, trained, and employed in the accountable entities.

The HSTP is building the foundation for effective interventions that "break-through" the financing and delivery system disconnects, and build partnerships across payment systems, delivery systems and medical/social support systems that effectively align financial incentives and more effectively meet the real life needs of individuals and their families. Indeed, the HSTP has already been a catalyst for the provider community to collaborate in innovative ways that leverage each other's expertise.

As a result of the HSTP and other health care delivery transformation efforts in the state, Rhode Island anticipates achieving the following objectives by 2022:

- Improvements in the balance of long term care utilization and expenditures, away from institutional and into community-based care;
- Decreases in readmission rates, preventable hospitalizations and preventable ED visits;
- Increase in the provision of coordinated primary care and behavioral health services in the same setting; and
- Increased numbers of Medicaid members who choose or are assigned to a primary care practice that functions as a patient centered medical home (as recognized by EOHHS).

Over the next Demonstration period, EOHHS' focus will be on further building on the foundation established by the HSTP, as well as refining other aspects of our Medicaid operations to ensure that the program delivers effective, high-quality care in a manner that is efficient and sustainable.

1.4. Rhode Island Section 1115 Demonstration Waiver Extension Request

The guiding principles of this Demonstration extension request reaffirm and expand on RI's commitment to:

- Pay for value, not volume;
- Coordinate physical, behavioral, and long-term health care;
- Rebalance the delivery system away from high-cost settings;
- Promote efficiency, transparency, and flexibility.

Rhode Island seeks the authorities necessary to ensure that, in pursuing these ends, the Rhode Island Medicaid program is sustainable in the future. Specifically, Rhode Island requests a five-year extension of the current Demonstration under Section 1115(e) of the Social Security Act (the Act), beginning January 1, 2019 and ending December 31, 2023.

EOHHS requests that all current authorities remain in force, and seeks additional authorities as outlined in Section 8. Each of the requested waivers detailed in the eligibility, benefits, delivery system, and finance sections of this document, aligns with one or more of the principles, as described in Table 1.2, and will be essential tools to achieving the goals outlined under each principle.

Table 1.2: Alignment of Waiver Requests with Rhode Island Medicaid Principles

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Waiver	**Pay for value, not for volume**	**Coordinate physical, behavioral, & long-term health care**	**Rebalance the delivery system away from high-cost settings**	**Promote efficiency, transparency, and flexibility**
Eligibility:				
Streamlining the Process for Collecting Beneficiary Liability to Decrease Provider Burden and Improve Program Integrity		**X**		**X**
Medicaid LTSS for Adults with Developmental and Intellectual Disabilities Group Homes		**X**	**X**	**X**
Facilitating Medicaid Eligibility for Children with Special Needs			**X**	**X**
Benefits:				
Covering Family Home Visiting Programs to Improve Birth and Early Childhood Outcomes		**X**	**X**	**X**
Supporting Home- and Community-Based Therapeutic Services for the Adult Population	**X**	**X**	**X**	**X**
Enhancing Peer Support Services for Parents and Youth Navigating Behavioral Health Challenges		**X**	**X**	**X**
Improving Access to Care for Homebound Individuals		**X**	**X**	**X**
Building Supports for Individuals in a Mental Health or Substance Use Crisis	**X**	**X**	**X**	
Providing Clinical Expertise to Primary Care through Telephonic Psychiatric Consultation		**X**	**X**	**X**
Facilitating Successful Transitions to Community Living		**X**	**X**	**X**
Ensuring the Effectiveness of Long-Term Services and Supports		**X**	**X**	**X**
Modernizing the Preventive and Core Home- and Community-Based Services Benefit Package		**X**	**X**	**X**

Delivery System:				
DSHP Claiming and Expenditure Authority for a Full Five Years	**X**	**X**	**X**	**X**
Piloting Dental Case Management		**X**	**X**	**X**
Promoting Access to Appropriate, High-Quality Mental Health and Substance Use Treatment by Waiving the IMD Exclusion		**X**		**X**
Finance:				
Testing New Personal Care and Homemaker Services Payment Methodologies Aimed at Increasing Provider Accountability	**X**	**X**	**X**	**X**

Section 2. Demonstration Eligibility

2.1 Introduction

Rhode Island's Medicaid program provides an essential safety net for many Rhode Islanders. The program ensures low income and vulnerable populations have access to high quality health care services, mostly through Medicaid MCOs that are consistently ranked in the top ten in national NCQA rankings for Medicaid MCOs. All of the eligibility groups covered presently by Medicaid are included within the Rhode Island Section 1115 Comprehensive Demonstration. In the waiver extension period, EOHHS will continue to cover all of these eligibility groups, including categorically eligible groups (mandatory and optional), medically needy (mandatory and optional), groups that could be covered under the Medicaid State Plan but are covered under the Demonstration, and groups that are covered under the Demonstration authority.

As of December 2017, EOHHS's Medicaid program was serving 315,000 enrollees, nearly a third of the State's population. This reflects a 61.5% increase over the December 2013 enrollment and an average annual increase of 12.8% (inclusive of the new adult population group). Table 2.1 provides year-end snapshot by eligibility group for the past five years. EOHHS Medicaid anticipates more stable growth for the foreseeable future: 5% for RIte Care and the New Adult Group, 2% for ABD with TPL, and 0% for ABD without TPL and CSHCN.

Table 2.1 Enrollment Snapshot as of December 31, by Medicaid Eligibility Group (MEG), 2013 - 2017

MEG	*2013*	*2014*	*2015*	*2016*	*2017*	*Net Change*	*Annual Growth Rate*
RIte Care	*127,579*	*145,745*	*153,419*	*166,118*	*168,728*	*32.3%*	*7.2%*
CSHCN	*10,923*	*10,995*	*10,831*	*10,912*	*11,058*	*1.2%*	*0.3%*
ABD MA Only	*23,731*	*20,068*	*18,707*	*19,245*	*19,974*	*-15.8%*	*-4.2%*
ABD Dual	*32,149*	*33,298*	*33,575*	*34,529*	*35,920*	*11.7%*	*2.8%*
Expansion		*59,654*	*65,582*	*75,980*	*79,083*	*32.6%*	*9.9%*
Grand Total	*194,382*	*269,760*	*282,114*	*306,784*	*314,763*	*61.9%*	*12.8%*

2.2 Current Eligibility Groups

Tables 2.2 through 2.7 below summarize the eligibility groups included within the current waiver grouped by *Eligibility Groups Under the Approved State Plan as of November 2008* and *Eligibility Groups Under the Demonstration*. EOHHS is requesting the authority for each of these groups to be continued in the five-year extension period. In the table, eligibility groups are displayed in accordance with current rules.

Eligibility Groups Under the Approved State Plan as of November 1, 2008

Table 2.2: Mandatory Categorically Needy Coverage Groups

Table 2.2: 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

Table 2.2: Mandatory Categorically Needy Coverage Groups		
Medicaid Eligibility Groups	**Income and Resource Standards and/or Other Qualifying Criteria**	**Expenditure and CMS 64 Eligibility Group Reporting**
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 postpartum 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

Table 2.2: Mandatory Categorically Needy Coverage Groups		
Medicaid Eligibility Groups	**Income and Resource Standards and/or Other Qualifying Criteria**	**Expenditure and CMS 64 Eligibility Group Reporting**
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

Table 2.3: Optional Categorically Needy Coverage Groups

Table 2.3: 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

Table 2.3: Optional Categorically Needy Coverage Groups		
Medicaid Eligibility Groups	**Income and Resource Standards and/or Other Qualifying Criteria**	**Expenditure and CMS 64 Eligibility Group Reporting**
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	*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 eligibility requirements	Budget Population 14 BCCTP

Table 2.4: Mandatory Medically Needy Coverage Groups

Table 2.4: 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

Table 2.5: Optional Medically Needy Coverage Groups

Table 2.5: Optional Medically Needy Coverage Groups		
Medicaid Eligibility Groups	**Income and Resource Standards and/or Other Qualifying Criteria**	**Expenditure and CMS 64 Eligibility Group**
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]EOHHS 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

Table 2.6: Groups That Could Be Covered Under the Medicaid State Plan but Gain Eligibility Through §1115 Demonstration

Table 2.6: Groups That Could Be Covered Under the Medicaid 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

Table 2.7: Expansion Groups

Table 2.7: Expansion Groups		
Medicaid Eligibility Groups	**Income and Resource Standards and/or Other Qualifying Criteria**	**Expenditure and CMS 64 Eligibility Group Reporting**
Women who lose Medicaid eligibility 60 days postpartum received 24 months of family planning services	*Income*: Up to 200% FPL *Resource*: No resource test	Budget Population 5 EFP
Children and families in managed care enrolled in RIte Care (children under 19 & parents) when the parents have behavioral health conditions (substance abuse/mental illness) that result in their children being placed in temporary State custody.	*Income:* up to 200% FPL *Resource:* No resource limit	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

Table 2.7: Expansion Groups		
Medicaid Eligibility Groups	**Income and Resource Standards and/or Other Qualifying Criteria**	**Expenditure and CMS 64 Eligibility Group Reporting**
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 State had 1915(c) waiver programs.	Budget Population 12 217 & PACE like Categorically needy High
Medically needy under the State Plan receiving HCBW services in the community (high and highest group) Medically needy PACE-like participants in the community	Apply the medically needy income standard plus $400 and use institutional eligibility rules, including the application of spousal impoverishment eligibility rules.	Budget Population 13 217 & PACE like Medically needy High & Highest
Adults with disabilities served by the Office of Rehabilitation Services (ORS) who are not eligible for Medicaid, but may become 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.

Table 2.7: Expansion Groups		
Medicaid Eligibility Groups	**Income and Resource Standards and/or Other Qualifying Criteria**	**Expenditure and CMS 64 Eligibility Group Reporting**
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:* No resource limit	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:* No resource limit	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:* No resource limit	Budget Population 19 Non-working disabled adults

2.3 Eligibility Changes Sought in Waiver Extension

Eligibility Waiver Request Item #1: Streamlining the Process for Collecting Beneficiary Liability to Decrease Provider Burden and Improve Program Integrity

Description of Change:
EOHHS proposes a new approach to the collection of beneficiary liability to mirror the way EOHHS collects monthly premiums for those who enroll in the Medicaid premium assistance program. That is, EOHHS will collect the beneficiary liability directly from the Medicaid eligible individuals rather than having providers collect them. This change would solely address the process of collection; the methodology for determining the application of beneficiary income to the cost of care will remain the same.

Target Population:
The target population for this request is Medicaid beneficiaries subject to cost of care.

Waiver Authority Sought:
EOHHS seeks to waive 42 CFR 435.725 and 435.726 to allow EOHHS to collect the beneficiary liability directly from the Medicaid eligible individual.

Rationale:
Current federal regulations at 42 CFR 435.725 and 435.726 require State Medicaid agencies to determine a person's cost of care and then collect that amount from the individual. Currently, EOHHS reduces provider payments by the beneficiary cost of care, and the provider must then to collect those funds from the beneficiary.

EOHHS seeks to decrease provider burden by collecting beneficiary liability directly from the Medicaid eligible individual. When a person is in a nursing home, it is relatively simple to deduct the beneficiary liability from one provider. However, the current process of decreasing provider payments by the beneficiary cost of care becomes more difficult when individuals move from a nursing home to the community because they may be receiving services from multiple providers: home health agency; adult day care; assisted living, for example. Long-term services and supports (LTSS) providers spend a considerable amount of time pursuing that beneficiary liability. Removing this administrative burden from providers and having EOHHS collect beneficiary liability directly from beneficiaries would free up provider resources so they can focus on providing care.

Additionally, providers do not have an incentive to report when a person does not pay their share of costs as the consequence would be loss of Medicaid eligibility for the client. However, as administrators of the program, EOHHS must ensure that beneficiaries comply with applicable eligibility requirements, including the requirement to share in their cost of care. EOHHS believes collecting beneficiary liability directly from the individual will strengthen program integrity by helping to identify individuals who do not comply with their obligations to share in the cost of care, and enabling the agency to implement tools to recover those funds.

Eligibility Waiver Request Item #2: Medicaid LTSS for Adults with Developmental and Intellectual Disabilities Group Homes

Description of Change:

EOHHS seeks to codify the needs-based criteria for determining the service options available to adults with developmental and intellectual disabilities (DD/ID) who meet the level of care for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).
to care for this population since the 1980s. In accordance with the principles articulated in the *Olmstead* decision, the State now reserves access to institutionally-based care for only those individuals with needs that cannot be safely and effectively met in a less restrictive service option. Due to the limited number of available ICF/IID beds, these beneficiaries may be temporarily placed in licensed health care institutions with the capacity to provide a similar or higher level of care (e.g., long-term care hospital). For the most part, however, the State uses Medicaid home- and community-based service options to address DD/ID beneficiaries' LTSS needs, including community supportive living arrangements and home care.

The RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) administers the Medicaid long-term services and support program for adults with DD/ID who would require the level of care typically available in an ICF/IID in Rhode Island were it not for home and community-based (HCBS) service options provided. EOHHS proposes to

formalize the tiered criteria for evaluating service needs established under the authority of its existing Section 1115 demonstration waiver. This will clarify the array of service options associated with each tier after the first full year of implementing an updated version of the Supports Intensity Scale – Adult Version (SIS-A), the nationally recognized instrument of choice for assessing DD/ID level of need.

The SIS-A measures service and support requirements in 57 life activities and 28 behavioral and medical areas including, but not limited to, home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. BHDDH has established the scope of need classifications based on the SIS-A that cover the highest and high levels of need, as authorized in the current Section 1115 demonstration waiver. There are several tiered gradations within each – e.g., (Tiers D and E = highest with "extraordinary needs" and Tier C = Highest with "significant needs"). The SIS-A scores define and differentiate the level of need at each tier. The available DD/ID LTSS service options have been mapped to correspond with these tiered levels of need as indicated in the Table 2.7 below:

Table 2.7: DD/ID Needs-Based Service Tier Classifications and Options

Table 2.7: DD/ID Needs-Based Service Tier Classifications and Options		
Tier	**Service Options**	**Available Supports**
Tier D and E (Highest): ***Extraordinary Needs***	• Living with family/caregiver • Independent Living • Shared Living • Community Support Residence • Group Home/Specialized Group Home	• Community Residential Support or access to overnight support services • Integrated Employment Supports • Integrated Community and/or Day supports • Transportation
Tier C (Highest): ***Significant Needs***	• Living with family/caregiver • Independent Living • Shared Living • Community Support Residence • Group Home	• Community Residential Support or access to overnight support services • Integrated Employment Supports • Integrated Community and/or Day supports • Transportation
Tier B (High): ***Moderate Needs***	• Living with family/ caregiver • Independent Living • Shared Living • *Group Home	• Access to overnight support services • Integrated Employment supports • Integrated Community and/or Day supports • Transportation

Tier A (High): ***Mild Needs***	• Living with Family/Caregiver • Independent Living • Community Support Residence • **Shared Living • *Group Home	• Access to overnight support services • Integrated Employment supports • Integrated Community and/or Day Supports • Transportation

* Tier A or B individuals will have access to residential services in a group home if they meet at least one defined exception.
** Tier A will have access to Shared Living services if they meet at least one defined exception.

An institutional placement generally would only be available for beneficiaries who have extraordinary needs (Tier D and E) and have extenuating circumstances requiring access to 24-hour skilled care and a highly restrictive setting. Therefore, the DD/ID service matrix focuses on HCBS and the settings and supports available at each tier depending on the beneficiary's unique needs and circumstances. The State's goal is to continue and expand ongoing efforts to provide LTSS to DD/ID beneficiaries in settings that promote inclusion, encourage independence and self-direction, and facilitate supportive employment while still providing high quality and appropriate services and supports.

EOHHS is adopting rules, that identify certain "exceptions" which enable a beneficiary to access service options that do not correspond to their level of need tier. In these situations, the scope of authorized supports remains tied to the tiers even though the setting has changed. Such exceptional circumstances include:

1. Loss of primary caregiver due to hospitalization, debilitating illness, or death of spouse, caretaker sibling or adult child;
2. Loss of living situation due to fire, flood, foreclosure, or sale of principal residence due to inability to maintain housing expenses;
3. A principal treating health care provider or discharge planner indicates that based on a functional/clinical assessment, the health and welfare of the applicant/beneficiary is at imminent risk if services are not provided or if services are discontinued; or
4. The applicant/beneficiary met the highest level of care criteria on or before June 30, 2015 and chose to receive Medicaid LTSS at home or in a community-setting, and the beneficiary reports experiencing a failed placement that, if continued, may pose risks to the beneficiary's health and safety; or
5. The beneficiary was admitted to a hospital or NF and is being discharged back to the original setting within any given 40-day period;
6. The beneficiary has legal or court involvement related to an assessed community safety risk that requires the provision of intensive supports or supervision associated with residential support services.

Each person will undergo a Situational Assessment of Need (SAN) to assess his or her qualification for an exception and need for the 24-hour supervision of a group home or shared living settings. The service level, meaning the scope of Medicaid HCBS supports authorized, will still be based on the original service classification (Tier) generated from the SIS.

Target Population:
This waiver request targets adults with DD/ID who are eligible for Medicaid LTSS based on a disability characteristic.

Waiver Authority Sought:
EOHHS seeks to clarify it use of existing waiver authority related to Section 1902(a)(17), Comparability of Eligibility Standards.

Rationale:
Data show over-utilization of community group homes as a service option for beneficiaries with lower level needs in Rhode Island. For example, according to the National Core Indicators (NCI) 2015-2016 data, the percentage of DD/ID beneficiaries living in group home residences with a capacity of 4-6 individuals was 28% in Rhode Island compared to 15% nationally. The State's own data support this finding and shows the full scope of care provided. Currently, approximately 33% of the Medicaid DD/ID beneficiaries receiving LTSS reside in a community group home staffed 24 hours per day, seven days per week.

Based on SIS-A scores, many of the beneficiaries within the adult system would fare well if provided with a service option that encourages greater self-care and autonomy. Accordingly, EOHHS the State developed additional service classifications using the SIS-A criteria that more clearly differentiate level of need within the high and highest categories. Studies conducted by independent researchers like the Human Services Research Institute (HSRI) have encouraged and assisted states in developing tiers based on an algorithm of scores generated by the SIS. EOHHS has used a similar approach with a few exceptions.

Using tiers based on this methodology enables EOHHS to make informed decisions about which service option (i.e., community setting) best meets a beneficiary's needs and provides the least restrictive living environment. This, in turn, has enhanced the State's capacity to comply with the federal HCBS Final Rule and the *Olmstead* decision, both of which affirm the rights of persons with DD/ID to receive services in the most integrated and least restrictive settings appropriate for their needs.

The Supports Intensity Scale ranks each activity according to the *frequency* (refers to how often support is needed), *amount* (refers to how much time in one day another person is needed to provide support), and *type* of support (refers to what kind of support should be provided). Additionally, the behavioral and medical section of the SIS-A rates exceptional medical and behavioral support needs. Finally, a Supports Intensity Level is determined based on the Total Support Needs Index, which is a standard score generated from scores on all the items tested by the Scale.

Finally, the State's DD/ID tiered needs-based criteria assures that all beneficiaries will continue to have access to the services they need. The investment in home- and community-based alternatives, and the availability of timely and appropriate placements, depends on utilization of community group homes reserved for those with extraordinary support and/or those in emergent situations that require access to intensive services.

Eligibility Waiver Request Item #3: Facilitating Medicaid Eligibility for Children with Special Needs

Description of Change:
The Social Security Act's Section 1902(r)(2) allows states to vary methods of determining financial eligibility with "less restrictive methodologies" for counting income and resources. EOHHS proposes to exercise this option to allow EOHHS to cover disabled children who by themselves would meet the Social Security Income disability standards but could not receive SSI cash payments due to family income and resource limits. However, EOHHS seeks a waiver to limit this option to disabled children who need care in a residential treatment facility.

Target Population:
This waiver request targets children who meet the SSI disability criteria and require care in a residential treatment facility.

Waiver Authority Sought:
EOHHS seeks to limit the application of Section 1902(r)(2) to children who meet the SSI disability criteria and require care in a residential treatment facility.

Rationale:
In Rhode Island, approximately 100 families with children who have severe emotional disturbance (SED) or other mental health issues and need long-term placement into a residential treatment facility have had to relinquish custody of their children to the Department of Children Youth and Families (DCYF). In these cases, there is no child maltreatment and the sole reason for DCYF involvement is to get the children Medicaid eligibility so that the child can receive appropriate care in a residential treatment facility.

Requiring families of children with SED or other mental health conditions to relinquish parental rights to get the appropriate treatment for their children is harmful and counter-productive. As such, EOHHS seeks to establish an alternative Medicaid eligibility pathway for these children with specials needs.

EOHHS intends to exercise state flexibility under Section 1902(r)(2) to use less restrictive methodologies to calculate Medicaid eligibility. More specifically, EOHHS would establish an eligibility category for children who meet the SSI disability criteria, but whose household income and assets exceed the SSI resource limits. Under this methodology, EOHHS proposes to count children as a household of one; parents' income and resources would not be considered in determining the child's eligibility for Medicaid. For a child with disabilities to be eligible through this pathway, the family must first apply for SSI for the child. Once the SSA deems the child ineligible based on household resources, the child could apply for Medicaid through this new pathway as a household of one.

However, EOHHS proposes to limit this methodology to disabled children who have a demonstrated need for care in a residential treatment facility. This would allow EOHHS to target those who have the greatest need and mitigate the budget impact to the state and federal government. EOHHS anticipates that this proposal would result in the same children who are placed into DCYF custody being eligible through the new pathway. The most significant difference would be that families would no longer have to relinquish custody of their children to access Medicaid coverage.

Section 3. Demonstration Benefits

3.1 Introduction

Though the current Demonstration benefits approved by CMS have been instrumental to turning the Medicaid program into a cost-effective and sustainable investment, some of Medicaid's most vulnerable populations still have limited access to care. Limited access to medical, dental, and substance use care leads to delivery of care in high-cost settings like nursing facilities, residential treatment facilities, hospitals, and emergency departments that could have been avoided if the right care was provided at the right time and in the right setting.

EOHHS has identified additional benefits that will provide EOHHS Medicaid's more fragile members with greater access to care and requests authority for the benefits detailed in Section 3.2. The flexibility to cover these additional benefits will reduce the utilization of more intensive and higher cost services, and improve health outcomes for individuals who are medically fragile, have behavioral health and substance use diagnoses, those with developmental disabilities, and those individuals that prefer to remain in the community although eligible for institutional long-term care. All current State Plan Amendments and pending 1115 Waiver Amendments (Category Changes) will remain in-force.

3.2 Changes to Benefits Sought in Waiver Extension

Benefits Waiver Request Item #1: Covering Family Home Visiting Programs to Improve Birth and Early Childhood Outcomes

Description of Change:
EOHHS, in collaboration with the Rhode Island Department of Health, seeks authority to use Medicaid financing for evidence-based home visiting services, as defined by the Maternal, Infant, and Early Childhood Home Visiting Program and the U.S. Department of Health and Human Services' HomVEE project. These services include home visits by trained professionals – using evidence-based curricula – to improve maternal and child health outcomes, encourage positive parenting, and promote child development and school readiness. These programs also help families access and stay engaged with other support services that improve outcomes, such as adult education programs or the Women, Infants and Children Supplemental Nutrition program.

Target Population:
The population that would receive family home visiting services include Medicaid-eligible pregnant women and children up to age four who are at-risk for adverse health, behavioral, and educational outcomes. Risk for poor outcomes will be identified using an evidence-based tool, such as the Family/Parent Survey, that assesses maternal and child health, including mental health, social supports, infant development and maternal infant relationships. The program will prioritize families that have multiple risk factors for poor outcomes.

Waiver Authority Sought:
EOHHS requests a waiver of Section 1902 (a)(10)(B), Amount, Duration, and Scope of services to cover family home visiting services for Medicaid eligible pregnant women and children up to age four.

Rationale:
A person's early childhood experiences have dramatic and lasting impacts throughout his or her life. The first five years of life are most essential to later positive development; during the early years, children develop foundational capabilities in cognition, language and literacy, emotional growth, and reasoning. Experiences during this period are critical in many ways, including how they set us on paths leading toward – or away from – good health.

Home visiting programs that help families provide a nurturing, health environment to children have a strong evidence base for improving outcomes. Children whose parents participated in home visiting programs are less likely to have low birthweight, more likely to be breastfed by their mothers, and more likely to be up-to-date on recommended well child visits and immunizations. These children also experience fewer child injuries, and are less likely to suffer from child abuse, neglect and maltreatment. Studies also show that birth parents enrolled in home visiting programs have improved prenatal health, are more likely to receive recommended prenatal and postpartum visits, and have improved mental health and ability to cope with parenting.

In 2010, the federal government established the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to expand and improve state-administered home visiting programs for at-risk families with young children. Rhode Island implements these services through Nurse-Family Partnership (NFP) and Healthy Families America (HFA) as part of the MIECHV program.

NFP enrolls low-income, first-time mothers and their children with in-home support services delivered by a registered nurse. The model includes one-on-one home visits, that begin early in the woman's pregnancy (before 28 weeks) and conclude when the woman's child turns 2 years old. NFP is designed to improve prenatal health and outcomes, child health and development, families' economic self-sufficiency and/or maternal life course development. It does this by building on family strengths, and uses coaching, modelling and motivational interviewing with the parents to set and achieve goals. NFP produces positive returns on investment, saving states money by reducing pre-term births infant mortality, and emergency department visits among children. Research shows that the program reduces lifelong costs to Medicaid by 10%.[2]

HFA enrolls low-income, high-risk families. The model includes one-on-one home visits that can begin prenatally or just after the birth of the child. Children may stay in the program until age 3. HFA is designed to improve maternal and child health, children's social emotional well-being, school readiness, and connections to appropriate social support services. HFA reduces child maltreatment, and HFA saves states money because it has a positive impact on children's health and development, including mental health. [3] This intervention resulted in longer intervals between

[2] Miller, T. (2013). Nurse family partnership home visitation: costs, outcomes, and return on investment. HBSA, Inc. Retrieved from http://iik.org/wp-content/uploads/2017/12/Costs_and_ROI_executive_summary.pdf
[3] Lee, E., et al. (2009). Reducing low birth weight through home visitation: A randomized controlled trial. *American Journal of Preventative Medicine,* 36 (2009): 154–160. doi: 10.1016/j.amepre.2008.09.029

pregnancies, reduced low birth weight, and reduced birth complications. It also reduced emergency department use among families. [4]

In Rhode Island, approximately 1,000 children born each year have at least three risk factors (i.e. maternal age less than 20 years, low maternal education, Medicaid eligibility, single parenthood, etc.) for poor outcomes and would benefit from participating in evidence-based home visiting programs. However, currently the state is only able to serve approximately one-third of those families. The MIECHV program is a critical federal investment, and additional resources are needed to reach all the families who would benefit from these services. This authority would allow RI to sustain interventions that are proven to result in better health outcomes for both parent and child, as well as reduce future Medicaid costs.

Benefits Waiver Request Item #2: Supporting Home- and Community-Based Therapeutic Services for the Adult Population

Description of Change:
EOHHS requests the authority to provide home- and community-based therapeutic services (HBTS) to adults with a behavioral health diagnosis and/or developmental disability. EOHHS currently covers in-home/community-based skill building and therapeutic/clinical services for children and requests expanding the population eligible for these types services to include adults. Services may include, but are not limited to, evidence based practices; home-based specialized treatment; home-based treatment support; individual-specific orientation; transitional services; lead therapy; life skill building; specialized treatment consultation by a behavioral health clinician; and treatment coordination.

Target Population:
The target population includes Medicaid beneficiaries at least 21 years of age that have at least one of the following:

- A Chronic condition such as arthritis, asthma, diabetes, heart disease, special needs (such as autism) and diseases (such as cancer);
- A Behavioral health diagnosis;
- A Neurological diagnosis; or
- Significant impairment in level of functioning as determined by a validated screening tool.

Waiver Authority Sought:
EOHHS requests a waiver of Section 1902 (a)(10)(B), Amount, Duration, and Scope of services to expand the population eligible to receive home- and community-based therapeutic services to include Medicaid eligible individuals over 21 years old who have moderate to severe special health care needs due to chronic developmental, cognitive, physical, medical, neurological, and behavioral and/or emotional conditions, or developmental disabilities.

[4] Mitchell-Herzfeld, S., et al (2005). Evaluation of healthy families New York: first year program impacts. The New York State Office of Children and Family Services, Bureau of Evaluation and Research. Retrieved from:ocfs.state.ny.us/main/prevention/assets/HFNY_FirstYearProgramImpacts.pdf

Rationale:
EOHHS has worked to provide a vast array of services to meet the needs of at-risk and vulnerable populations. Currently, however, programs and services are set up to support identified populations in isolation or under a distinct authority/state agency. For example, a certain set of services are available only to children with special health care needs, while another set of services might target adults with severe and persistent mental illness of our medically compromised aging populations. Treatment services are often population-specific and do not allow for continuity of care as a person inevitably ages and transitions from one identified population to another. Current available services (e.g. intensive care management, home-based therapeutic services for children under age 21, homemaker services, and assertive community treatment for the SPMI population) also do not fill in treatment gaps created by the fragmented system.

Service gaps include social skill building, home-based therapeutic services for adults, support with transitions, life skills training, psychiatric consultation (provider to provider) and other evidence-based practices designed to support individuals and preserve their ability to receive care in the least restrictive setting. These services are crucial to assist young adults with a BH or DD/ID diagnosis to transition from the child system to the adult system, and to also assist the aging population who often linger in higher levels of care (skilled nursing facilities) due to BH, DD/ID diagnoses and the lack of specialized services that address their unique needs.

Expanding the population eligible for these services to include adults will allow for the support needed during transitions between levels of care. The EOHHS Nursing Home Transition Program makes the connection with many supports and services in the community, however, in-home behavioral health clinical support is missing from this list. According to the 2012 review, Care Transition Interventions in Mental Health, preventable hospital readmissions and other difficulties in care transitions are worldwide problems, reducing quality and increasing costs.[5] This is a special problem in behavioral health in which there has been much less model development and intervention testing for improvement of care transitions than in general medical care.

EOHHS requests the authority to provide services to individuals with a BH and/or DD/ID diagnosis based on an individuals' needs, not on an individual's categorization, regardless of being a child or adult. The following are examples of services that would be beneficial to be offered to adults as well as children/youth:

- **Home Based Therapeutic Services:** A therapeutic service that occurs in the community, typically the family home to ensure that the family/ child has the supports in place to fully succeed without having to access a higher level of care.

- **Applied Behavior Analysis:** The process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior.

[5] Viggiano, T., Pincus, H.A., & Stephen, C. (2012). Care transition interventions in mental health. Current Opinion in Psychology, 25(6), 551-558.

- **Coordinated Specialty Care:** An evidence-based approach to delivering effective treatment for individuals and families recovering from a first episode of psychosis.

- **Healthy Transitions:** A model that improves access to treatment and support services for 16- to 25-year-olds who have, or are at risk of developing, a serious mental health condition.

- **Seven Challenges:** A counseling program for young people that incorporates work on alcohol and other drug problems. It is designed to motivate youth to evaluate their lives, consider changes they may wish to make, and then succeed in implementing the desired changes.

Benefit Waiver Request Item #3: Enhancing Peer Support Services for Parents and Youth Navigating Behavioral Health Challenges

Description of Change:
On February 8, 2018, CMS approved a waiver amendment request for expenditures on services delivered by peer recovery specialists (submitted to CMS in 2015). As stated in the approved STCs, peer recovery specialists provide "an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connections to the community, as well as offer services, that focus on the treatment of mental health and/or substance use disorders for those individuals who have trouble stabilizing in the community and/or in need of supports to maintain their stability in the community."

The current authority focuses on services to facilitate individuals' recovery from illness, addiction or institutionalization. EOHHS seeks to build upon this request to provide peer-to-peer mentoring supports that go beyond recovery navigation. EOHHS also seeks to expand the population eligible for mentoring supports to include parents and youth who are hard to engage and require multi-agency involvement and support. The service would be claimed as part of Budget Services 4 for at risk youth, and claiming would occur under the Medicaid-eligible youth's name.

These peer mentoring supports will emphasize supporting youth with serious emotional disturbance and their parents or children and parents for whom a parent-child relational disorder has been diagnosed that may result in long-term behavioral health issues.

Target Population:
The population that will be eligible for peer mentoring supports include children, youth, and young adults who have complex behavioral health needs and are at risk of having to leave the home due to child welfare or juvenile justice involvement or who may need extended residential psychiatric treatment. The services will help with family stabilization to either expedite reunification of a child back home or support a child to remain in his/her community. Through this service, peer support providers who struggled with and successfully overcame behavioral health challenges as youth may work directly with current youth deemed in need of the service, or parent support providers who have parented youth involved in the behavioral health, child welfare, juvenile justice or other youth serving systems may support parents or caregivers directly to enhance the parent/caregivers' ability to address their child's behavioral health.

Waiver Authority Sought:
EOHHS requests to waive Section 1902(a)(10)(B), amount, duration, and scope, to offer peer mentoring services to children, youth, and young adults who have complex behavioral health needs and are at risk of removal from the home due to child welfare or juvenile justice involvement, or who may need extended residential psychiatric treatment.

Rationale:
Families of youth with serious emotional disturbances (SED) often have difficulties with engagement and accessing services. The families need education and support on how to best address the emotional and behavioral health needs of the youth.

Parent and youth peer support is an essential component of a system of care for these children and youth. These supports help to build the resiliency of caregivers and youth, and strengthen families' capacity to care for children at home. Parent and youth peer support providers are distinct from traditional mental health service providers in that they operate out of their personal experience and knowledge to promote the well-being of families with whom they work.

The peer support services that would be provided include but are not limited to:

- Teaching families the skills necessary to improve coping abilities;
- Increasing parents' and caregivers' knowledge for meeting their child's education and social/emotional health needs;
- Promoting positive parenting skills;
- Developing and linking children, youth and parents/caregiver with formal and informal supports; and
- Helping families to secure basic needs, and access health insurance or social service benefits.

As indicated by the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration, parent and youth peer supports significantly enhance positive outcomes for children and youth.[6] In addition, many state and local initiatives aimed at addressing mental and behavioral health issues have included peer-to-peer support services for youth with mental health conditions and their parents, guardians, or caregivers.
According to the literature on parent and youth peer supports:

- Peer support programs help parents who have children with special needs find and become reliable allies for each other. They provide parents with the opportunity to connect with and support each other through informational and emotional support, and through reciprocity.[7]

[6] Centers for Medicare & Medicaid Services and Substance Abuse and Mental Health Services Administration. *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions.* May 7, 2013. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf (accessed, February 2, 2018).
[7] B. Santelli, A. Turnbull, J. Marquis, and E. Lerner. "Parent-to-Parent Programs: A Resource for Parents and Professionals." Journal of Early Intervention, 21, no.1 (1997), 73-83.

- The self-efficacy and empowerment of families can be enhanced by providing family support, and this has been associated with a variety of improved outcomes such as increased engagement, increased knowledge about the youth's condition and relevant services, and youth functioning at discharge.[8]

- There is encouraging initial evidence of the value of family education and support (FES) in reducing child symptoms and improving child functioning. There is evidence of some benefits to the parents and caregivers, including a reduction of stress, improved mental health and well-being, increased self-efficacy, perceived social supports, and increased treatment engagement.[9]

When parent and youth peer mentoring was provided within Rhode Island through the Family Care Community Partnership (FCCP) wraparound service, 63% of families successfully transitioned from an FCCP with service goals met versus only 38.6% of families when no peer mentor was provided.[10]

Benefits Waiver Request Item #4: Improving Access to Care for Homebound Individuals

Description of Change:
Rhode Island requests authority to pay for home-based primary care services for targeted individuals with functional limitations and other barriers that make it difficult to access needed healthcare services outside of the home.

Target Population:
The target population includes Medicaid-eligible individuals who are homebound, have functional limitations that make it difficult to access office-based primary care, or for whom routine office-based primary care is not effective because of complex medical, social, and/or behavioral health conditions.

Waiver Authority Sought:
EOHHS requests a waiver of Section 1902 (a)(10)(B), Amount, Duration, and Scope of services to cover home-based primary care services only for Medicaid-eligible individuals who are homebound, have functional limitations that make it difficult to access primary care, or for whom

[8] L. Bickman, C. Heflinger, D. Northrup, S. Sonnichsen, and S. Schilling. "Long Term Outcomes to Family Caregiver Empowerment." *Journal of Child and Family Studies,* 7, no. 3 (1998a), 269-282; C. Heflinger, L. Bickman, D. Northrup, and S. Sonnichsen. A theory-Driven Intervention and Evaluation to Explore Family Caregiver Empowerment." *Journal of Emotional and Behavioral Disorders,* 5, no. 3 (1997), 184-191; and M.G. Resendez, R.M. Quist, and D.G.M. Matshazi. A Longitudinal Analysis of Family Empowerment and Client Outcomes," *Journal of Child and Family Studies,* 9, no. 4 (2000), 449-460.
[9] K. Kutash, L.G. Garraza, J.M. Ferron, A.J. Duchnowski, C. Walrath, and A.L. Green. "The Relationship between Family Education and Support Services and Parent and Child Outcomes Over Time." Journal of Emotional and Behavioral Disorders, published online, August 2012.
[10] Rhode Island Department of Children, Youth & Families, Data and Evaluation Unit. "Rhode Island Family Care Community Partnerships Semi-annual Report, CY15 1st and 2nd Quarters Data." July 2015.

routine office-based primary care is not effective because of complex medical, social, and/or behavioral health conditions.

Rationale:
Individuals with functional limitations often have difficulty leaving their homes to access needed health care, including primary care services.[11,12] People with complex medical, social, and/or behavioral health conditions can face other challenges (e.g., severe fatigue, pain, mistrust of the health care system) that create barriers to using office-based services. These myriad challenges often lead to patients failing to schedule or keep appointments, being non-compliant with medication or other treatments, and relying heavily on emergency care, resulting in higher rates of emergency department visits and hospitalizations, decreased coordination of care, and poorer health outcomes.[11]

Delivering primary care services in the home offers a promising, cost-effective solution. Home-based primary care differs from home care services, which typically are used to help treat specific acute conditions. For example, home care may involve providing physical therapy after a fall or administering wound care for an infection. In contrast, home-based primary care providers care for the whole patient – the same type of care patients would receive by visiting their primary care physician in office settings.

Studies show that access to home-based primary care services can reduce hospitalizations and nursing facility use, lower health care costs, and improve quality of care. In addition to being cost-effective, it can increase patients' involvement with their care because it offers a personalized solution that allows patients to maintain comfort and dignity. Indeed, research shows that recipients of home based primary care have higher rates of patient and family satisfaction.[11,13,14,15,16]

Of the estimated 2 million people in the nation that are homebound, only 11.9% reported receiving primary care services at home, suggesting that there is a significant unmet need for home based

[11] Klein, S., Hostetter, M., & McCarthy, D. (2017). An overview of home-based primary care: Learning from the field. Issue brief (Commonwealth Fund), 15, 1. Retrieved from http://www.commonwealthfund.org/publications/issue-briefs/2017/jun/overview-home-based-primary-care
[12] Ornstein, K. A., Leff, B., Covinsky, K. E., Ritchie, C. S., Federman, A. D., Roberts, L., ... & Szanton, S. L. (2015). Epidemiology of the homebound population in the United States. Journal of the American Medical Association Internal Medicine, 175(7), 1180-1186. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/26010119
[13] Stall, N., Nowaczynski, M., & Sinha, S. K. (2014). Systematic review of outcomes from home-based primary care programs for homebound older adults. Journal of the American Geriatrics Society, 62(12), 2243-2251. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/jgs.13088/full
[14] Edes, T., Kinosian, B., Vuckovic, N. H., Olivia Nichols, L., Mary Becker, M., & Hossain, M. (2014). Better access, quality, and cost for clinically complex veterans with home-based primary care. Journal of the American Geriatrics Society, 62(10), 1954-1961. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/jgs.13030/full
[15] Eric De Jonge, K., Jamshed, N., Gilden, D., Kubisiak, J., Bruce, S. R., & Taler, G. (2014). Effects of home-based primary care on Medicare costs in high-risk elders. Journal of the American Geriatrics Society, 62(10), 1825-1831. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/jgs.12974/full
[16] Totten, A. M., White-Chu, E. F., Wasson, N., Morgan, E., Kansagara, D., Davis-O'Reilly, C., & Goodlin, S. (2016). Home-based primary care interventions. Retrieved from https://effectivehealthcare.ahrq.gov/topics/home-based-care/research/

primary care services.[17] Medicaid reimbursement of home-based primary care will allow EOHHS to enhance access to care and provide higher quality, cost-effective care for the homebound and medically frail populations.

Benefits Waiver Request Item #5: Building Supports for Individuals in a Behavioral Health Crisis

Description of Change:
EOHHS seeks authority for expenditures for a Behavioral Health Link (BH Link) triage center to support crisis stabilization and short-term treatment for individuals experiencing a behavioral health (mental health or substance use disorder) crisis. This triage center will provide access to specialized emergency behavioral healthcare services in a less costly and more appropriate setting than emergency departments. Initially, there will be only one provider that can receive reimbursement for this service, which will operate 24 hours a day, 7 days a week. When it becomes evident that there is a need for more than one triage center, EOHHS will announce and solicit other providers.

The BH Link triage center provider will receive a bundled rate that may be billed no more than once per client per 24-hour period. The bundled rate will include physician services, medication prescribing and management, skilled nursing, behavioral health services provided by qualified Mental Health Professionals, comprehensive assessment and triage, crisis stabilization and management, behavioral disorder evaluations, treatment identification and facilitation, system navigation, peer support, case management, engagement and follow-up care post initial assessment, and discharge coordination. All of these services will be available on site directly from staff 24/7 or through telemedicine. In addition, staff from the triage center who respond to crises in the community through a mobile intervention, will have access to all triage staff.

The provider will be required to meet EOHHS certification standards that will address minimal staffing levels, availability (e.g., must be open 24 hours per day, 7 days per week), the protocols for referral and warm handoffs to other treatment resources, and affiliation with the BH Link hotline.

Target Population:
The target population includes Medicaid eligible adults who are in crisis due to substance use disorders, mental health disorders or co-occurring mental health and substance use disorders.

Waiver Authority Sought:
EOHHS requests a waiver of Sections 1902(a)(1), state-wideness, and 1902(a)(23), free choice of providers, to allow EOHHS to limit the number of triage centers based on community needs.

Rationale:
ED visits involving mental health and substance use disorders are considered potentially avoidable. If these conditions were adequately managed through appropriate outpatient care, then ED visits

should be reduced. These potentially preventable mental health and substance use-related visits are also more than twice as likely to result in hospital admission compared with ED visits that do not involve mental health or substance use disorders.[18]

EOHHS' analysis of Medicaid claims data from state fiscal years 2014 through 2016 shows that mental illness was among four primary diagnoses that accounted for 50 percent of emergency department (ED) claims. Moreover, the proportion of individuals with a mental health diagnosis seeking ED services increased each year. This data indicates the need for effective mental health crisis response services in Rhode Island.

A well-designed crisis response system can provide back-up to community providers, perform outreach by connecting first-time users to appropriate services and improve community relations by providing assurance that the person's needs are met in a behavioral health crisis. One component to EOHHS' strategy for addressing the needs of individuals going through a behavioral health crisis is to develop community-based crisis stabilization – through BH Link triage centers – for persons who may need short, intensive treatment in a safe environment that is less restrictive and traumatizing than a hospital. The individuals who staff the BH Link triage center(s) will be experts in behavioral health, and therefore more skilled and appropriate to meet the needs of the individuals presenting.

EOHHS recently received authority for the Recovery Navigation Program (RNP), which provides crisis stabilization, case management, peer support and referral services to individuals that are under the influence of substances in a setting that is less costly and less intensive than the Emergency Department. However, the RNP does not cover services for individuals that may have a mental health crisis without a substance use disorder. RNP also does not provide short-term treatment services by licensed healthcare providers.

Consequently, EOHHS seeks authority for a Behavioral Health Link triage center, which builds upon the RNP to expand the eligible population and to strengthen the services available to ensure that individuals have more immediate access to treatment after a behavioral health crisis before returning home. 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 triage center will also have some capacity to do mobile outreach to individuals in crisis locally.

EOHHS' requirement for the BH Link triage center to be open 24 hours a day, 7 days a week means that there must be sufficient demand for the services to be financially viable. As such, EOHHS requests a waiver of Sections 1902(a)(1), state-wideness, and 1902(a)(23), free choice of providers, to allow EOHHS to set up one triage center until such time that there is evidence of need for additional BH Link triage centers.

[18] Owens PL, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits Among Adults, 2007. HCUP Statistical Brief #92. July 2010. U.S. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf. Accessed March 21, 2018.

Benefits Waiver Request Item #6: Providing Clinical Expertise to Primary Care through Telephonic Psychiatric Consultation

Description of Change:
EOHHS seeks authority to cover child, adolescent and adult telephonic psychiatric consultation services for primary care practitioners. Through the State Innovation Model grant, RI established a program known as the Pediatric Psychiatry Resource Network (or "PediPRN"), which provides reimbursement for same day phone consultation between a pediatric primary care practitioner and a board-certified child psychiatrist. EOHHS intends to expand support for these consultative services by making them Medicaid-reimbursable for primary care physicians who use these services in the course of caring for their Medicaid eligible patients.

Target Population:
This proposal would support the primary care providers of Medicaid-eligible children, adolescents and adults.

Waiver Authority Sought:
Expenditure Authority under 1115(a)(2) of the Act to provide reimbursement for telephonic psychiatric consultations to primary care providers.

Rationale:
Integrating mental health services into a primary care setting increases the chances of ensuring that individuals have access to appropriate behavioral health treatment. Primary care providers are frequently the main point of contact in the health care system for people who experience behavioral and mental health issues. However, they often lack the training to fully address the wide range of psychosocial issues presented by their patients. They may not have the necessary tools to make a diagnosis, or the requisite knowledge on the appropriate medications to prescribe for particular mental health conditions. This results in missed opportunities for early identification and treatment.

The need for both pediatric and adult psychiatric services is high in Rhode Island. In State Fiscal Year (SFY) 2016, 22 percent (24,860) of children in Medicaid had a mental health diagnosis. In addition, mental health-related emergency department visits among children increased 33 percent, from 1,269 visits in 2015 to 1,690 in 2016.[19] The Substance Abuse and Mental Health Services Administration (SAMSHA) reports that in 2016, 5.4 percent (843,905) of Rhode Island's general population were diagnosed with Serious Mental Illness (SMI).[20]

Rhode Island has challenges serving individuals with behavioral and mental health needs, having fewer behavioral health and substance abuse counselors per capita than other New England states.

[19] Rhode Island KIDS COUNT (2017). *Rhode Island kids count factbook*. Retrieved from http://www.rikidscount.org/Portals/0/Uploads/Documents/Factbook%202017/2017%20RI%20Kids%20Count%20Factbook%20for%20website.pdf

[20] Substance Abuse & Mental Health Services Administration, Drug & Alcohol Services Information System. (2017). SMI/SED prevalence estimates [Data file]. Retrieved from https://wwwdasis.samhsa.gov/dasis2/urs.htm

Seven percent of Rhode Island adults aged 18 years and older had perceived unmet mental health care needs – the highest in New England and the United States.[21]

This service gap leads to potentially avoidable hospital stays that unnecessarily increase program costs. In 2013, inpatient hospital stays made up 22 percent of state Medicaid spending on behavioral health. In 2014, 13,083 Rhode Island Medicaid beneficiaries were diagnosed with depression, which is the fourth most costly chronic condition in the state. Additionally, about 9.5 percent ($789 million) of the state's 2015 budget was attributed to indirect costs associated with behavioral health disorders.[22]

Giving primary care providers access to psychiatric consultation can help individuals with behavioral and mental health needs receive appropriate care. These consultations may include assistance with diagnosis, treatment planning, obtaining a second opinion, screening support, and support on prescribing of psychotropic medication. With Medicaid coverage of these consultation services, primary care physicians serving Medicaid beneficiaries will be better able to meet the needs of patients with common mental health conditions, such as attention deficit hyperactivity disorder and mild depression. It will also help PCPs make connections to appropriate care for individuals requiring specialty psychiatric care and/or medications that are not appropriately managed in the primary care setting.

Benefits Waiver Request Item #7: Facilitating Successful Transitions to Community Living

Description of Change:
EOHHS currently has authority to provide community transition services as a community-based Core service for adults who are eligible for Medicaid based on age, blindness or disability, and have a high or highest level of care determination. Under the current authority, community transition services are defined as "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." EOHHS seeks to: 1) recharacterize community transition services as a Preventive service, rather than a Core community-based service; 2) offer community transition services to a broader population than is currently eligible; and 3) expand the allowable expenses that can be covered under this authority.

Target Population:
The target population includes Medicaid eligible elders and adults with disabilities who reside in nursing facilities, as well as Medicaid eligible elders and adults who are hospitalized or receiving short-term skilled nursing facility services, are at high risk for institutionalization due to clinical

[21] Truven Health Analytics, (2015). Rhode Island behavioral health project: final report. Retrieved from: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Truven%20Rhode%20Island%20Behavioral%20Health%20Final%20Report%209%2015%202015.pdf
[22] Rhode Island State Innovation Model (SIM) Test Grant Operational Plan (Version 2). Retrieved from: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/State%20Innovation%20Model/RISIMOperationalandIPHPlan.pdf

needs and/or functional limitations and need assistance with health-related social needs to continue residing in the community.

Waiver Authority Sought:
EOHHS requests a waiver of Section 1902 (a)(10)(B), Amount, Duration, and Scope of services to cover community transition services only for Medicaid eligible elders and adults who have a high or highest level of care determination; and Medicaid eligible elders and adults who are hospitalized or receiving short-term skilled nursing facility services, are at high risk for institutionalization due to clinical needs and/or functional limitations, and need assistance with health-related social needs in order to continue residing in the community.

Rationale:
Currently, community transition services are categorized as a community-based Core service, and therefore only available to individuals who already have a Medicaid long-term care eligibility determination. However, nursing facility residents are far more likely to return to the community within the first 90 days of a nursing facility stay than after 90 days; only 8% of community transitions are for long-stay residents who have been in facility for more than 90 days.[23,24] Consequently, community transition efforts will be more successful if services are initiated as early as possible in the nursing facility stay, rather than only after long-term care eligibility is determined.[25,26] Further, some individuals in hospitals at high risk for institutionalization may be more likely to return to the community before a nursing facility admission if they have adequate supports. This would allow Rhode Island to interrupt one of the main pathways to a long-term nursing facility stay.[26] Recharacterizing community transition services as a Preventive service and expanding the eligible population, will allow EOHHS to simplify and streamline the process for Medicaid beneficiaries to qualify for these benefits, facilitate timely access, and ensure that the services are provided to beneficiaries at a point in their care when the services can be most effective.

In addition, EOHHS seeks to expand the benefit to better address the health and social barriers to transition that often extend Medicaid-covered nursing facility stays and can prevent a return to the community. Anecdotal reports from nursing facilities and data from the Money Follows the Person Program point to an increase in the chronically homeless individuals in nursing facilities who may be able to return to the community. For instance, the number of chronically homeless people referred to the Money Follows the Person Program increased from 8 (2% of referrals) in 2012 to 57 (15% of referrals) in 2017.

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[23] Gassoumis, Z. D., Fike, K. T., Rahman, A. N., Enguidanos, S. M., & Wilber, K. H. (2013). Who transitions to the community from nursing homes? Comparing patterns and predictors for short-stay and long-stay residents. *Home Health Care Services Quarterly, 32*(2), 75–91. Retrieved from: http://doi.org/10.1080/01621424.2013.779353
[24] Arling, G., Kane, R. L., Cooke, V., & Lewis, T. (2010). Targeting residents for transitions from nursing home to community. *Health Services Research, 45*(3), 691–711. Retrieved from: http://doi.org/10.1111/j.1475-6773.2010.01105.x
[25] Optum. *Transitioning nursing facility residents back to home and community settings*. White paper. Retrieved from: https://www.optum.com/content/dam/optum/resources/whitePapers/transitioning-nursing-facility-residents-back-home-community-settings.pdf
[26] Alecxih, L. (2013). *Estimated savings from early intervention*. Presentation. The Lewin Group. Retrieved from: http://nasuad.org/documentation/HCBS_2013/Presentations/9.10%2010.15-11.30%20Arlington.pdf

To better serve this population, EOHHS proposes to expand the allowable expenses to include: storage fees; weather appropriate clothing; assistance with obtaining needed items for housing applications (e.g., assistance with obtaining and paying for a birth certificate or a state identification card, transportation to the local Social Security office); short-term assistance with rental costs for people who are at imminent risk of homelessness and are likely to be institutionalized in the absence of safe housing or who are in an institution and are unable to secure new housing without financial assistance (e.g., past due rent with housing agencies); and a short-term supply of food when people transition from the nursing facility or the hospital to the community.

State staff, nursing facilities, and other partners identify these expenses as barriers to nursing facility transition for Medicaid beneficiaries. Studies show that interventions to address unmet social needs can improve outcomes and reduce use of nursing facility and other high cost health care services for Medicaid beneficiaries.[27,28,29,30] Rhode Island anticipates that targeted strategies to address specific health and social barriers to nursing home transition will allow more Medicaid beneficiaries to successfully return to the community and will, in turn, improve the success of the state's transition efforts.

Benefits Waiver Request Item #8: Ensuring the Effectiveness of Long-Term Services and Supports

Description of Change:

EOHHS requests to modify the expedited eligibility process for long-term services and supports to facilitate timely placement and delivery of home and community-based services. Specifically, EOHHS proposes to use a more efficient, clinical/functional expedited eligibility review process that employs a shortened, concise application that will capture the information needed to identify individuals who qualify for LTSS. Medical health providers will attest to this information, which will be used to confirm a person's level of care and develop an interim service plan. The current process for self-attestation of financial eligibility criteria would remain unchanged.

In addition, EOHHS proposes to expand the benefit package that is available to individuals who are pending a final eligibility determination for LTSS benefits as follows:

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[27] Heiman, H.J., & Artiga, S. (2015, November). *Beyond health care: The role of social determinants in promoting health and health equity.* Issue Brief. Kaiser Commission on Medicaid and the Uninsured. Retrieved from: http://files.kff.org/attachment/issue-brief-beyond-health-care

[28] Lee, J., & Korba, C. *Social determinants of health: How are hospitals and health systems investing in and addressing social needs?* Deloitte Center for Health Solutions. Retrieved from: https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-addressing-social-determinants-of-health.pdf

[29] Thomas, K. S., & Mor, V. (2013). Providing more home-delivered meals is one way to keep older adults with low care needs out of nursing homes. *Health Affairs (Project Hope)*, 32(10), 1796–1802. Retrieved from: http://doi.org/10.1377/hlthaff.2013.0390

[30] Shier G, Ginsburg M, Howell J, Volland P, Golden R. (2013). Strong social support services, such as transportation and help for caregivers, can lead to lower health care use and costs. *Health Affairs (Millwood)*. 2013 Mar;32(3):544-51. doi: 10.1377/hlthaff.2012.0170. P

- including LTSS preventive HCBS (identified in Benefits Waiver Request Item #9 below and Attachment B: Core and Preventive Home and Community Based Services Definitions);
- increasing the number of days that adult day care services may be covered from three (3) to five (5) days per week; and
- including an option to provide additional hours of personal care/homemaker services above the twenty (20) hours currently allowed for beneficiaries with the highest clinical/functional need for an institutional level of care.

These improvements will enable EOHHS to make medically necessary services (including skilled nursing services) available to those waiting for a final Medicaid eligibility determination, which in turn should avert institutionalization or facilitate more successful transitions from institutional care settings to the community.

Target Population:
The target population includes adults and elders who have submitted a completed application for Medicaid Long-Term Services and Supports (LTSS) and are seeking care in the home or community-based settings. This includes:

- current Medicaid beneficiaries who are eligible based on receipt of SSI or the State Plan authority extending eligibility to elders and adults with disabilities with income up to 100 percent of the FPL;
- those eligible for the state's Division of Elderly Affairs co-pay program (Budget Population 10); and
- persons participating in the Medicare Premium Payment Program and/or Integrated Care Initiative – dual Medicare/Medicaid Demonstration project in managed care – who have been determined at-risk for LTSS.

New Medicaid applicants seeking LTSS must meet all general eligibility requirements (e.g., age, residency, immigration status, and citizenship) and provide evidence of a continuous need for LTSS as specified in federal regulations and self-attest to income and resources within the limits defined in the Medicaid State Plan and the applicable sections of the Rhode Island Code of Rules (RICR).

Waiver Authority Sought:
EOHHS seeks to modify its existing expenditure authority (#10), which allows spending for long-term care benefits pending verification of financial eligibility criteria to be matchable under RI's title XIX plan.

Rationale:
The proposed changes will allow EOHHS to make more timely eligibility determinations for LTSS services, and provide a robust package of services and supports to individuals who have a High or the Highest need for an institutional level of care and are pending a full eligibility.

Research shows that upon admission, most nursing home residents prefer to be discharged into the community. However, the preference to return home declines as the length of the nursing home

stay increases and supports for community discharge declines.[31] Although the number one barrier to transitioning nursing home residents into the community is access to affordable, safe housing, financial constraints caused in part by delays in Medicaid eligibility determinations are also a contributing factor.[32]

To mitigate the impact of eligibility determination delays, EOHHS proposes to implement an LTSS expedited eligibility program, similar to what other states (e.g., Pennsylvania and Washington) have done. These states' experiences, though still in the early stages, confirms that expedited LTSS eligibility – focusing on HCBS – optimizes health and reduces LTSS costs by preserving access to housing, promoting self-care and independence, and ultimately delays/diverts placement into nursing facilities.[33]

As described above, EOHHS proposes to use a more efficient, clinical/functional expedited eligibility review process that employs a shortened, concise application that will capture the information needed to identify those who qualify for LTSS. Medical health providers will attest to this information, which will be used to confirm a person's level of care and develop an interim service plan. The current process requires that a lengthy functional needs assessment be conducted in the home by a social worker as well as a medical evaluation form submitted by medical providers. Only after receipt of both can EOHHS nurses determine a level of care and authorize services. This process is unnecessarily time- and human resource-intensive, duplicative (providers and case worker both assessing same person) and delays service delivery. EOHHS intends to institute an intensive, early person-centered planning protocol as part of the new business process under development for efficiently assessing clinical/functional need when initiating expedited eligibility. Using the information received from the medical providers that have already had an encounter with the member will eliminate duplication of efforts and markedly reduce the timeframe for completing the clinical component of the eligibility process.

While this new clinical review process will shorten the timeframe for application processing, applicants for LTSS will still experience some wait for a final eligibility determination. To better meet LTSS applicants' needs, EOHHS proposes to enhance the benefit package available to individuals who are pending a final LTSS eligibility determination.

Several of the services that EOHHS proposes to add have been shown to improve outcomes. For example, research shows that expanded access to adult day reduces readmissions and emergency department usage. Providing care in this less restrictive setting is also more appropriate, and helps

[31] Arling, G., Kane, R., Cooke, V., & Lewis, T. (2010). Targeting residents for transitions from nursing home to community. Health Services Research, 45(3), 691-711. doi: 10.1111/j.1475-6773.2010.01105.x

[32]O'Malley Watts, M., Reaves, E.L., & Musumeci, M. (2015). Money follows the person: a 2015 state survey of transitions, services, and costs. The Kaiser Commission on Medicaid and the Uninsured. Retrieved from https://www.kff.org/medicaid/report/money-follows-the-person-a-2015-state-survey-of-transitions-services-and-costs/

[33] Summer, L. (2005). Strategies to keep consumers needing long-term care in the community and out of nursing facilities. The Kaiser Commission on Medicaid and the Uninsured. Retrieved from: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/strategies-to-keep-consumers-needing-long-term-care-in-the-community-and-out-of-nursing-facilities-report.pdf .

preserve independence and encourage social interaction.[34] Increasing the availability of adult day services available from three (3) to five (5) days will thus strengthen rebalancing efforts, especially for those beneficiaries who would prefer services outside the home on a regular or even interim basis.

In addition, EOHHS' evaluation of personal care/homemaker services found that many HCBS beneficiaries require between 10 to 15 percent more hours of service at the outset than the 20 hours allowed under the existing expedited eligibility authority. Having the option to provide more hours of personal care/homemaker services would allow EOHHS to better meet the needs of our beneficiaries.

Currently, many individuals cannot receive Preventive HCBS until they have been determined Medicaid eligible. Although adult day health and personal care/homemaker services are supportive in keeping beneficiaries safe in the community, this package is limited in scope. Allowing individuals to receive all Preventive HCBS while a full Medicaid eligibility determination is pending will further ensure that risks of admissions to nursing facilities or visits to the emergency department are not augmented.

In sum, an expedited clinical review process and an expanded expedited eligibility benefit will allow EOHHS to provide timely access to robust set of services and supports that are critical to meeting the needs of a very vulnerable population. It will also promote EOHHS' rebalancing goals, and ensure that individuals can access services in the most appropriate setting.

Benefits Waiver Request Item #9: Modernizing the Preventive and Core Home- and Community-Based Services Benefit Package

Description:
EOHHS seeks to modernize the Preventive and Core Home and Community Based Service (HCBS) package for beneficiaries who meet the applicable clinical/functional criteria. Specifically, EOHHS proposes to: (1) eliminate select HCBS that are no longer needed as they are now State Plan benefits; (2) broaden the range of needs-based Preventive and Core HCBS; (3) update the definitions of the benefits; and (4) institute authority to cap the amount or duration of Preventive HCBS based on need and mandate cost-sharing for Preventive HCBS.

Target Population:
Medicaid beneficiaries eligible based on age, disability or blindness who meet the applicable clinical/functional criteria.

Waiver Authority Sought:
EOHHS seeks to use its existing authority to waive Section 1902(a)(10)(B) and 1915c to modify its currently authorized LTSS Preventive HCBS option.

[34] Jones, K., Tullai-McGuinness, S., Dolansky, M., Farag, A., Krivanek, M., & Matthews, L. (2011). Expanded adult day program as a transition from hospital to home. Policy, Politics & Nursing Practice, 12(1), 18-26. doi: 10.1177/1527154411409052

Rationale:
Currently in Rhode Island, 79% of Medicaid long-term care spending pays for institutional care and 21% of Medicaid long-term care spending is for home and community based services.[35] This is markedly higher than that of the national average of 47.8%. [36] There have been numerous incremental efforts to enhance the LTSS system in Rhode Island, which has led to a decline in nursing home days per thousand over the last 5 years. However, these investments have not made a significant impact, as the total expenses for nursing homes continues grow.

Absent the capacity on the state level to transform the delivery system to one that does not rely so heavily on institutional care settings, the current issues will have compounding impacts. The growing aging population in the state brings increased urgency to these reforms. The U.S. Census Bureau projections indicate that the portion of U.S. adults over the age of 65 years will increase from 14.5% of the total population in 2015 to 20.3% of the total population in 2030.[37] With strong support from Governor Gina Raimondo, EOHHS is embarking on a redesign of its LTSS delivery system. Thorough stakeholder input processes will be coordinated to identify the key initiatives that will be most impactful to rebalancing the system. This investment is necessary to ensure that EOHHS' next LTSS initiatives are well-informed and strategic in nature.

In support of this redesign process, EOHHS reviewed the current HCBS benefit package. Through the internal discussions as well as from the input received from stakeholders, it was clear that there needed to be more benefits available to those meeting all levels of care and there needed to be flexibilities established to ensure that beneficiary's access was not significantly impacted if there are future budget shortfalls.

Eliminate Select HCBS
EOHHS proposes to eliminate a few waiver authorities that are no longer needed as they are now State Plan benefits. These include Environmental Modifications and Minor Environmental Modifications, Physical Therapy Evaluation and Services, and Adult Day Health Services. These services are now available to the entire Medicaid population and therefore do not need to be stated as HCBS.

Broaden the Range of Needs-Based Preventive and Core HCBS
EOHHS has implemented the authority for the HCBS option since initial approval of the state's Section 1115 Waiver Demonstration in 2009. An internal evaluation of the benefit between 2009 and 2013 indicates that access to Preventive HCBS effectively decreased the utilization of high cost interventions for beneficiaries with certain chronic conditions by as much as 30 percent in any given year.[38] The evaluation showed that elderly beneficiaries who had diabetes or congestive

[35] SFY 2016 data from RI's Medicaid Management Information System (MMIS).
[36] Kaiser Family Foundation (2016). State health facts: Distribution of fee-for-service Medicaid spending on long term care [Data file]. Retrieved from https://www.kff.org/medicaid/state-indicator/spending-on-long-term-care/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[37] U.S Census Bureau, U.S. Department of Commerce. (2012). Projections of the population by selected age groups and sex for the United States: 2015 to 2060, middle series [Date file]. Retrieved from https://www.census.gov/data/tables/2012/demo/popproj/2012-summary-tables.html

heart failure and received Preventive HCBS had 25 percent fewer hospitalizations, used fewer prescription pain-killers and anti-depressants, and were significantly less likely to require podiatric and orthopedic interventions than their counterparts who did not receive Preventive HCBS benefits.

Moreover, a 2014 Lewin Group study of the state's rebalancing efforts found evidence that Preventive HCBS provided to beneficiaries enrolled in Connect Care Choice – the state's no longer active Primary Care Case Management program – delayed the need for a nursing facility level of care by 18 months or more for adults and elders with chronic conditions.[39] These findings demonstrate that the Preventive HCBS option reduces the utilization of high cost services, decreases the rate of hospital admissions, and shortens inpatient stays. It allows individuals to maintain functional capacity and independence longer, thus increasing the likelihood that individuals who develop the need for an institutional level of care choose to remain in the community and receive HCBS instead.[40]

It is clear that current Preventive services have been instrumental in realizing reduced utilization and better outcomes. However, stakeholders and caregivers that are engaged with EOHHS have reported that there remain significant needs for additional services for the LTSS population. The range of Preventive services must be broadened to ensure that challenges faced by those individuals that are at risk of needing institutional care can be minimized. For example, the number one barrier to transitioning nursing home residents into the community for many states is access to affordable, safe housing.[41] Services such as home stabilization, community transition services, and peer supports will be a huge assistance to individuals that may otherwise become institutionalized simply because they cannot locate safe housing. For those that housing is not an issue, the concern shifts to services that will keep that environment safe, such as assistive technologies and chore services, and that will keep the individual safe in their home. Services such as medication management, assistive technologies, skilled nursing and non-emergency transportation were all identified as essential services to ensuring escalations in levels of care are prevented.

The additional Core services are needed to expand access to the settings in which individuals can be cared for. Shared living, adult foster care, and the supportive services for caregivers will expand the options available to those who are able to remain in community-based environments. Career planning and prevocational services were identified as supports that are needed to improve the employment planning processes that are critical to ensuring developmentally disabled individuals are afforded opportunities that are integrated in the community.

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[39] The Lewin Group (2014). Long-term services and supports evaluation of rebalancing strategies. Retrieved from: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/LTSSLewinReport103116.pdf

[40] Anthony, S., Traub, A., Lewis, S., Mann, C., Kruse, A., Herman Soper, M., Somers, S. (2017). Strengthening Medicaid long-term services and supports in an evolving policy environment: a toolkit for states. Center for Health Care Strategies, Inc. Retrieved from: https://www.chcs.org/resource/strengthening-medicaid-long-term-services-supports-evolving-policy-environment-toolkit-states/

[41] O'Malley Watts, M., Reaves, E.L., & Musumeci, M. (2015). Money follows the person: a 2015 state survey of transitions, services, and costs. The Kaiser Commission on Medicaid and the Uninsured. Retrieved from https://www.kff.org/medicaid/report/money-follows-the-person-a-2015-state-survey-of-transitions-services-and-costs/

Collectively, these authorities will allow EOHHS the ability to better serve some of the most vulnerable Medicaid members in their communities. EOHHS requests the authority to broaden the range of Preventive and Core HCBS by adding the following to the existing benefit package:

Table 3.1 Additional Preventive and Core HCBS Benefits

Additional Preventive HCBS	Additional Core HCBS
• Assistive technology, including Personal Emergency Response System (PERS) • Chore • Community Transition Services • Home stabilization • Limited non-medical transportation/home visits • Medication management/administration • Peer Supports • Skilled-nursing, when pre-authorized based on need	• Adult Foster Care • Assistive technology, including Personal Emergency Response System (PERS) • Bereavement Counseling • Career Planning • Chore • Community Transition Services • Consultative Clinical and Therapeutic Services • Home stabilization • Limited non-medical transportation/home visits • Medication management/administration • Peer Supports • Prevocational Services • Psychosocial Rehabilitation Services • Shared Living • Skilled-nursing, when pre-authorized based on need • Training and Counseling Services for Unpaid Caregivers

Update the Definition of HCBS Benefits

The current Core and Preventive HCBS definitions do not align with federal definitions and policies related to HCBS waiver services. Accordingly, EOHHS revised the definitions within the proposed list of the HCBS benefit package to align with changes in federal definitions and policy related to HCBS waiver services. This further clarifies the scope of benefits available to beneficiaries that meet the applicable level of care criteria. Except for Home Stabilization, Community Supportive Living Arrangements, and Peer Supports, the definitions in Attachment B, Core and Preventive Home- and Community-Based Service Definitions, of this 1115 Waiver Extension Request document are based on definitions provided in CMS' Technical Guidance for 1915(c) Home- and Community-Based Waivers.

Flexibility to Cap Preventive HCBS and Mandate Cost-Sharing for Preventive HCBS

EOHHS is also requesting two additional authorities that will allow preservation of the HCBS benefit package in the even that state appropriations are reduced. This includes the authority to cap the amount and/or duration of any Preventive HCBS based on an individual beneficiary's need and the authority to mandate cost-sharing for the Preventive HCBS. As HCBS are not defined as mandatory Medicaid benefits under the Social Security Act, they are subject to elimination if state

appropriations are reduced. State resources are already very limited, and EOHHS' ability to effectively and efficiently expend resources is critical. These authorities would allow EOHHS to implement processes that ensure that those most in need receive the appropriate services that enable them to remain safely at home or in the community. EOHHS will employ these authorities as an alternative to eliminating the services in the event of increased budget constraints.

Section 4. Cost Sharing Requirements

All existing cost sharing authorities will remain in force for the requested five-year extension period.

Section 5. Delivery System and Payment Rates for Services

5.1 Overview of EOHHS Medicaid Delivery System

All services provided through the Demonstration are administered through one of several Delivery Systems that can be distinguished by their payment mechanism (Capitated or Fee-for-Service) and source of case/care management. Managed Care Organizations (MCO) are responsible to manage all services provided to their members. EOHHS contracts with three health plans: 1) Neighborhood Health Plan of RI; 2) United Health Care of New England; and 3) Tufts Health Plan. Some beneficiaries can also opt-out of managed care arrangements altogether and fall into an exclusively fee-for-service delivery system.

Managed Care Organizations

RIte Care: Program for Families and Children administered by the MCOs. In addition, RIte Care includes all CHIP children as well as 90% of children in Substitute Care and 75% of Children with Special Health Care Needs (CSN). As of July 2017, there were 172,611 beneficiaries enrolled in RIteCare, 7,759 children enrolled in CSN, and 2,791 children enrolled in substitute care. This population also includes the Extended Family Planning Program and the Pregnant Expansion Population both of which are very small populations representing less than 1% of the Medicaid population.

Rhody Health Partners (RHP): Program for Aged, Blind and Disabled Adults (ABD) with no third-party liability (TPL) who are not eligible for long-term services and supports (LTSS). The program also enrolls adults in the new Medicaid Expansion population. The program is administered through the MCOs. As of July 2017, there are about 52,368 ABD adults enrolled in RHP along with about 80,833 people from the Adult Expansion population.

Rhody Health Options (RHO): Program for ABD adults eligible for LTSS who may or may not have TPL. Beneficiaries will have access to home and community based services either as an alternative to institutionalization or otherwise based on medical need. RHO is the responsible managed care entity for both institutional and HCBS services. As of July 2017, there are about 10,755 people enrolled in RHO.

RIte Smiles: Managed dental benefit program for children born on or after May 1, 2000. The program is administered through a pre-paid ambulatory health plan contract. As of July 2017, there are about 104,707 children enrolled in the RIte Smiles program.

Other Care Management Programs

Program for All-Inclusive Care for the Elderly (PACE): PACE is subsumed under this section 1115 Demonstration program and will remain an option for qualifying Demonstration eligible, that is, those that meet the High and Highest level of care determinations. EOHHS assures that Demonstration participants who may be eligible for the PACE program are furnished sufficient information about the PACE program to make an informed decision about whether to elect this option for receipt of services. EOHHS will comply with all Federal requirements governing its current PACE program, and any future expansion or new PACE program in accordance with

section 1934 of the Social Security Act and regulations at Part 460 of the Code of Federal Regulations.) As of August 2017, there were 297 beneficiaries participating in the PACE program.

Fee-for-Service (FFS)
Some populations may 'opt-out' of managed care programs and are eligible to receive services through traditional fee-for-service arrangements with providers. However, members who qualify for HCBS are required to have their LTSS managed by some managed care entity. Those who opt-out of one of the State's selected plans are placed in the Self-Direction program. Self-direction beneficiaries (or, as they authorize, their families) will also have the option to purchase HCBS waiver like services through a self-direction service delivery system. Under this option, beneficiaries will work with the ACO to develop a budget amount for services needed. The beneficiary, with the support of a fiscal intermediary, will then be able to purchase services directly. This option is based on experience from EOHHS's 1915(c) Cash and Counseling Waiver (*RI Personal Choice*), 1915(c) Developmental Disabilities Waiver, and Personal Assistance Service and Supports program. Self-Direction is fully described in the Self-Direction Operations Section of the STCs. As of July 2017, there are about 25,696 beneficiaries enrolled in FFS.

Marketplace Subsidies/Expansion Populations
Alternative Benefit Plan (ABP)**.** Effective January 1, 2014, the New Adult Group receive benefits through the state's approved alternative benefit plan (ABP) state plan amendment (SPA), which are effective as of the date in the approved ABP SPA. Individuals in the New Adult group may receive, as a part of their ABP under this Demonstration, Expenditure Authority services such as Managed Care Demonstration Only Benefits and will be referred to as enrolled in a Qualified Health Plan (QHP).

Table 5.1 Crosswalks Eligibility Type and Delivery System.

Table 5.1: Crosswalk of Eligibility Type and Delivery System	
Eligibility Type	Delivery System
Families with Dependent Children	Enrolled in RIte Care with one of three participating MCOs for medical care. Enrolled in 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 three participating MCOs
Children with Special Health Care needs	Enrolled in RIte Care with one of three participating MCOs. FFS for children with other comprehensive insurance coverage. Enrolled in RIte Smiles PAHP for dental benefits, if born on or after May 1, 2000.
Children in Substitute Care Arrangements	Enrolled in RIte Care with MCO selected by the Department of Children, Youth & Families. Enrolled in RIte Smiles PAHP for dental benefits, if born on or after May 1, 2000.

Table 5.1: Crosswalk of Eligibility Type and Delivery System	
Eligibility Type	Delivery System
Youth aged out of foster care system eligible under Affordable Care Act	Enrolled in RIte Care with MCO selected by the Department of Children, Youth & Families. Enrolled in 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 FFS wraps around that benefit.
Aged, Blind, and Disabled (ABD) Adults – Medicaid Only	Enrolled in Rhody Health Partners with one of three MCOs. FFS for persons with other comprehensive insurance coverage.
Aged, Blind, and Disabled (ABD) Adults – Medicare and Medicaid Eligible (MME)	Enrolled in Rhody Health Options or PACE
Childless Adults eligible under the Affordable Care Act	Enrolled in Rhody Health Partners with one of three MCOs.

5.2 Delivery System Changes Sought in Waiver Extension

Delivery System Waiver Request Item #1: DSHP Claiming and Expenditure Authority for a Full Five Years

Description of Change:
Under the terms of the current waiver, Rhode Island was authorized to claim FFP for a specified set of Designated State Health Programs (DSHPs) "to *solely to support the goals of the Health System Transformation Project*[42]" (HSTP). EOHHS is seeking continued authority for these previously authorized DSHP expenditures through December 31, 2020.

Waiver Authority Sought:
EOHHS requests to extend the Designated State Health Program (DSHP) authority through December 31, 2020, with an aggregate five-year DSHP expenditure cap (2016-2020) of $12,752,203 FFP.

Rationale:
This request is consistent with the terms specified in the CMS letter received by EOHHS on October 20, 2016, which stated:
"In support of Rhode Island's delivery system reform efforts, and because we have determined that each of these programs furthers the objectives of title XIX, CMS is approving expenditure authority for designated state health programs of $129.7 million over five years, contingent upon successful implementation of the demonstration."

[42] RI Special Terms and Conditions to the 1115 Waiver, STC #81

Since the waiver approval in October of 2016, EOHHS has made significant progress in transforming its healthcare delivery system. EOHHS has established partnerships with each public institute of higher education (IHE), and protocols for identifying and claiming DSHP expenditures. Following a robust stakeholder input process, EOHHS also identified the healthcare workforce development priorities and strategies.

The Comprehensive AE program is already underway, as Pilot AEs were certified in the fall of 2015 and APM contracts were in place between MCOs and Pilot AEs in 2016. As of Q3 2017, there were five certified Accountable Entities with APM contracts in place to support over 116,000 average attributed lives, capturing nearly half of the population enrolled in managed care.[43] EOHHS plans to move the Comprehensive AE program to full certification in CY 2018 with the first full program performance period beginning in July 2018, consistent with the MCO contract period.

Over time, this HSTP-funded infrastructure investment must be effectively "replaced" by the financial rewards of an effective APM/total cost of care model, and its associated shared savings opportunity. As such, EOHHS is committed to a five-year time horizon, from initial infrastructure investment, to full program implementation, and ultimately to self-sustaining risk bearing entities.

In accordance with this timeline, the Comprehensive AEs that have participated in the AE pilot program beginning in CY 2017 will complete a five-year progression to risk by CY 2022. Given this timeline, EOHHS requests continued authority for these previously authorized DSHP expenditures, through CY 2020, as was initially planned. This DSHP expenditure authority shall continue to "*solely support the goals of the Health System Transformation Project (HSTP*)" throughout the waiver term, supporting and enabling the effective progression of the HSTP to ensure investments in the healthcare workforce development are accomplished and to ensure that AEs are fully self-sustaining entities.

Delivery System Waiver Request Item #2: Piloting Dental Case Management

Description of Change:

Piloting dental case management in a select number of RI's dental practices is the third phase in the evolution of a three-year project called the RI Medicaid Adult Dental Case Management Learning Collaborative. The Collaborative included intensive training, resource development and support of dental case management within three diverse RI-based dental practices. As a first step towards a broader Medicaid Adult Dental Benefit transformation, EOHHS is preparing to pilot four new dental case management service codes to determine the potential effectiveness in advancing the use of these services among Medicaid beneficiaries in the future.

[43] Source: MCO Attributed Lives Snapshot Report as of Q3 2017. For reference - the total number of persons enrolled in an eligible managed care program in November 2017 was 254,611 (source RI Medicaid Managed Care Report issued on 12/7/2017). 142,000 persons represents ~45% of the eligible managed care population.

To date, the participating dental practices have increased access to oral health services for adults by using case management techniques that focus on arranging transportation, care coordination, motivational interviewing and improving the oral health literacy of their patients. However, despite the intense training, the practices cannot be reimbursed by Medicaid until the pilot that will monitor service code delivery is underway. Year 3 of the project has provided EOHHS time for the preparation of the pilot to test new policies within Medicaid, formalize a dental office case management curriculum to be used for dental provider case management "authorization," and focus on program design, policy development, financing and evaluation.

The new Dental Case Management (CM) Pilot is an opportunity for up to six (6) qualified dental practices in Rhode Island to participate in an unprecedented demonstration that will test the fiscal impact of four (4) new dental case management CDT codes. The testing will emphasize care coordination and alleviating transportation barriers in dental offices to support patient compliance. The pilot design requires dentists and their staff to complete online training modules that will give them the skills they need to bill for CM services. This initiative is the best way to determine if dental case management effectively improves patient outcomes. The statewide pilot practice settings will be a diverse mix of private practice, hospital-based dental clinic and federally-qualified health centers. The project would phase-in dental case management into standard Medicaid policy while monitoring utilization and fiscal feasibility.

The four, new dental case management codes were established by the Code Committee of the American Dental Association, and published in the 2017 Current Dental Terminology (CDT). The 12-month pilot will test the following dental CM codes:

Table 5.2 New Dental Case Management Codes

CDT Code	Short Code Description
D9991	Dental Case Management - addressing appointment compliance barriers
D9992	Dental Case Management - care coordination
D9993	Dental Case Management - motivational interviewing
D9994	Dental Case Management - patient education to improve oral health literacy

Target Population:
The target population for the pilot includes enrolled Medicaid adults ages 18 and over in a traditional fee-for-service dental delivery system.

Waiver Authority Sought:
This request is for a waiver of amount, duration, and scope to implement a Medicaid Case Management Pilot project using a select group of trained dental practices across the state. Four new dental case management CDT codes will be provided, billed for, reimbursed and monitored via claims data from MMIS and a customized data collection form. Dental case management benefits will be provided to adults ages 18 and over to only those patients of participating providers, and specifically to those persons identified within the participating practices as most in need and not in the same amount, duration, and scope to all other Medicaid enrollees.

Rationale:
The four goals of the initial Dental Case Management Learning Collaborative that preceded the Case Management Pilot were to improve access, productivity, financial stability and the quality and treatment of dental services provided to Medicaid-covered adult dental patients. With this in mind, dental case management addresses social determinants of health which can affect compliance with appointments and treatment recommendations. Further, the concept of dental case management aims to:

- Improve the member experience;
- Improve member oral health outcomes;
- Improve the provider experience by reducing no shows, late appointments, greater chance to improve patient oral health.

While delivering case management services is new in dentistry, it has a history of success in Medicaid on the medical side. In an August 2016 study, The National Institute for Health Care Management (NIHCM) found that CM can be success in changing health care service use and spending of nonelderly adult Medicaid enrollees. In addition, careful program targeting, strong patient engagement and frequent direct contacts between patients and case managers are important factors for a successful program.[44]

Table 5.3 outlines a sampling of other successful health outcomes from the delivery of case management services:[45]

Table 5.3 Sampling of Successful Health Outcomes From the Delivery of Case Management Services

State Medicaid Program	Outcome
VT	Beneficiaries with one or more chronic condition reported their adherence to proven care regimens relative to people with the same conditions who didn't participate in the program. ER use and inpatient hospital admissions dropped by 10 percent and 14 percent, respectively
NJ	Decreased high utilizers of hospital care; improved management of health conditions
OH	The MCO (CareSource) improved patient diabetes management
GA, IN & MN	Significant non-emergency ER divergence

[44] The National Institute for Health Care Management (NIHCM)-Sabik LM, Bazzoli GJ, Carcaise-Edinboro P, Chandan P, and Harpe SE. "The Impact of Integrated Case Management on Health Services Use and Spending Among Nonelderly Adult Medicaid Enrollees." Medical Care, 54(8):758-64, August 2016.
[45] Ibid.

Delivery System Waiver Request Item #3: Promoting Access to Appropriate, High-Quality Mental Health and Substance Use Treatment by Waiving the IMD Exclusion

Description of Change:
As defined in section 1905(i) of the Social Security Act and 42 CFR 435.1009, Institutions of Mental Disease (IMDs) are inpatient facilities of more than 16 beds that have patient rosters of people with severe mental illness of more than 51 percent. Federal financial participation is not available for services provided to people between the ages of 22 and 64 years even if they are otherwise Medicaid eligible. Rhode Island seeks to waive this IMD exclusion for persons who have mental health or substance use disorders and are participating in residential treatment programs with a census of 16 or more beds.

Target Population:
The requested waiver of the IMD exclusion will apply to Medicaid-eligible adults aged 21 to 64 years, regardless of delivery system, who have mental health or substance use disorders and who have a clinical need for residential treatment and the services and supports required to make a transition back into the community.

Waiver Authority Sought:
EOHHS requests a waiver of the IMD exclusion in section 1905(a)(29)(B) of the Social Security Act and 42 CFR 435.1009 to allow Medicaid coverage and federal financial participation for residential treatment services for Medicaid-eligible people in IMDs.

Rationale:
Since Medicaid's enactment in 1965, states have been barred from using federal dollars to pay for any services for a member between the ages of 21 and 64 while that member is a patient in an IMD. This rule, commonly referred to as the IMD exclusion or 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. The IMD exclusion ensured that states continued to be responsible for the costs of those large hospitals.

While the U.S. health care system and disability law have changed significantly since Medicaid was first enacted with the IMD exclusion in place, the IMD rule has largely remained unchanged. Regardless of the original intent, the rule imposes considerable constraints on states' ongoing efforts to implement integrated care models and achieve mental health parity.

Waiving the IMD rule would allow Rhode Island to maintain and enhance beneficiary access to behavioral health services in appropriate settings, and ensure that individuals receive care in the facility most appropriate to their needs. Because of the IMD exclusion, many Medicaid enrollees with behavioral health needs find their way to emergency departments in general hospitals. These care settings are often more expensive, and the clinicians are less prepared to address mental health and substance use issues.

The IMD exclusion undermines efforts to ensure continuity of care. For example, it incentivizes psychiatric facilities to release individuals sicker and quicker without appropriate referrals to community-based care since Medicaid will not pay for stays that exceed of 15 days. Even with today's advanced medications and the best available outpatient treatment services, a small but significant number of persons with psychiatric illnesses are treatment-resistant and require residential and institutional psychiatric care.

In addition, the IMD exclusion has severely limited Medicaid beneficiaries' access to substance use treatment programs and constrained the Medicaid-funded services and supports required for people to make successful transitions back to the community. All substance use treatment facilities with more than 16 beds are considered IMDs, despite evidence that certain substance use treatments, such as detoxification and rehabilitation services, often require longer stays in an inpatient facility. Rhode Island has nine (9) residential providers in twelve (12) different locations statewide. These providers implement clinically effective, evidence-based programs as part of an integrated system designed to promote overall health rather than just treat single conditions, diseases, or disorders. Most of these providers must maintain more than 16 beds to be financially viable, and are thus considered as IMDs. During SFY 2016, these providers served approximately 2,400 people, totaling over 3,000 stays. Of the over 3,000 stays, approximately 1,700 stays were for Medicaid-eligible beneficiaries. Over 1,000 of these stays were at IMDs.

Finally, restricting access to IMDs also raises parity issues after the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, since for no other conditions are Medicaid services in certain medical institutions excluded. The requirements of MHPAEA apply to Medicaid managed care coverage provided to those adults gaining Medicaid under the ACA.

Section 6. Demonstration Financing

6.1 Finance-Related Changes Sought in Waiver Extension

Finance Waiver Request Item #1: Testing New Personal Care and Homemaker Services Payment Methodologies Aimed at Increasing Provider Accountability

Description of Change:
EOHHS requests authority to pilot test and implement an alternative payment methodology (APM), such as bundled payments, per member per month payments, episodic payments, and quality-adjusted payments, for personal care and homemaker services. EOHHS will collaborate with providers, patient advocates, and other stakeholders to design, develop, pilot test with a limited number of providers, and evaluate the APM prior to statewide implementation.

Waiver Authority Sought:
Rhode Island requests a waiver of Section 1902(a)(23)(A) of the Act to pilot test APMs with a limited number of personal care and homemaker service providers.

Rationale:
EOHHS seeks to move away from fee-for-service payment methodologies toward value-based payment models that optimize the health and well-being of people eligible for long-term services and supports (LTSS), incentivize the use of home and community-based services over institutional care, increase provider flexibility to tailor service delivery to the unique needs of patients eligible for LTSS, and increase provider accountability for Medicaid beneficiaries' care and outcomes.

An APM will hold providers to a higher level of accountability for meeting quality and performance standards for their Medicaid patients' care and outcomes. It will also incentivize providers to better coordinate care with other providers across the care continuum and to more efficiently provide care based on the needs of patients. By piloting the APM with a limited number of providers initially, EOHHS will be able to operationalize and assess the APM, while minimizing disruption to the home care provider community.

Section 7. Budget Neutrality

Rhode Island's waiver Demonstration began in 2008, and has been in place for ten (10) years, including two five-year periods. EOHHS is seeking to extend this agreement for an additional five-year extension, as described below.

For the first five years of the waiver Demonstration (2008-2013), the budget neutrality limit was set at an aggregate amount of $12,075 million. Beginning with the current waiver period, January 1, 2014, the budget neutrality limit was determined by using a per capita cost method. Separate annual budget limits were calculated for each Demonstration year of the current waiver on a total computable basis using member months as reported to CMS. The annual limits were then added together with the prior aggregate cap amount ($12,075 million) to obtain a budget neutrality limit for the entire 10-year Demonstration period (2008-2018).

The current waiver period is a five-year arrangement, on a calendar year basis, which began on January 1, 2014 and ends on December 31, 2018. Rhode Island proposes to renew this waiver for an additional five years as follows:

Table 7.1: Waiver Timing

Demonstration Year 11	January 1, 2019 – December 31, 2019
Demonstration Year 12	January 1, 2020 – December 31, 2020
Demonstration Year 13	January 1, 2021 – December 31, 2021
Demonstration Year 14	January 1, 2022 – December 31, 2022
Demonstration Year 15	January 1, 2023 – December 31, 2023

In the current waiver period (2014-2018) EOHHS is subject to an aggregate budget neutrality target expenditure limit eligible to receive federal match. The per capita method means that EOHHS is at risk for the per capita cost for Demonstration populations, but not at risk for the number of participants in the Demonstration population.

Rhode Island seeks to extend this agreement for the additional five-year extension requested. Based on recent guidance from CMS, Rhode Island acknowledges that the budget neutrality limit will not be an aggregate amount for the entire 15-year Demonstration period. The budget neutrality limit for the extension period as proposed here includes an annual per capita cap for the Demonstration populations plus a carryforward amount based on budget neutrality savings from the current waiver period (DY 6-10, CY 2014-2018).

In projecting the budget neutrality limit for the proposed extension period, our starting point is the per capita budget neutrality limits for Demonstration Year 10 as set forth in paragraph 121 of the STCs, "Per Capita Budget Neutrality Limit and Aggregate Adjustment".[46] This is then used as the

[46] Rhode Island Comprehensive Demonstration Special Terms and Conditions Number 11-W-00242/1, Amended

base year in developing a "without waiver" forecast for Demonstration Year 11 through Demonstration year 15.

This Budget Neutrality section of Rhode Island's request further provides a "with waiver" forecast for the extension period. The with waiver forecast is developed using the same base year as the without waiver forecast, Demonstration Year 10, and then adjusted for the targeted impact of waiver initiatives over the five-year Demonstration period of 2019-2023.

Both the without waiver and with waiver forecasts will potentially be impacted by changes in the ACA at the federal level. Inherent uncertainties regarding future enrollment, costs and utilization for the extension period pose unique challenges, particularly in the context of budget neutrality. In particular, the continued uncertainty regarding the Medicaid expansion population is a primary reason for not including that population as an eligibility group within the waiver request. Rather, the Medicaid expansion population is treated here in the same manner as in the current waiver period, that is, as a hypothetical population.

B. Expenditures Subject to Budget Neutrality

Paragraph 102 of the STCs, "Reporting Expenditures Under the Demonstration" sets forth the guidelines for tracking and reporting of expenditures subject to budget neutrality. Expenditures will be allocated to the Demonstration Budget Populations and Budget Services identified in paragraph 102. The table in sub section c. of paragraph 102 lists a PMPM Grouping for each of the budget populations and services.

For the purposes of the Budget Neutrality calculations, these PMPM Groupings are divided into Regular and Hypothetical MEGs (Medicaid Eligibility Groups) as follows:

Regular MEGs:
ABD Adults NoTPL
ABD Adults TPL
RIteCare
CSHCN (Children with Special Healthcare Needs)

Hypothetical MEGs:
217-like Group
Family Planning Group
Low-Income Adult Group

All related expenditures will be reported in these MEGs in accordance with the CMS 64 reporting instructions.

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

In this extension, Rhode Island seeks to both build on its substantial financial accomplishments to date and continue to move its programs toward payment based on value and not volume. As such, EOHHS has developed targeted expenditure forecasts for the proposed extension waiver period as presented below. Expenditures are based on all federally matched Medicaid services.

Rhode Island's proposed budget neutrality limit for the extension period will consist of two components – a per capita component and an aggregate carryforward component. The per capita component is determined based on the forecasted WOW per member per month (PMPM) cost times the actual number of eligible member months as reported to CMS. The aggregate carryforward amount is based on the budget neutrality savings achieved during Demonstration Years 6-10. The aggregate carryforward amount will be added to the per capita limits to determine the cumulative budget neutrality limit for the extension Demonstration period.

The per capita component, shown in Table 7.2 below, is based on Rhode Island's forecasted WOW PMPMs by MEG for the extension period, DY 11-15. This WOW forecast uses the PMPMs from calendar year 2018 in STC 121, 122 and 123 as base year amounts. The base year amounts are trended forward at the current WOW trend rates by MEG to determine forecasted PMPMs for the rest of the extension period Demonstration years.

Table 7.2: Without Waiver Forecast Summary (WOW)

		Per Member Per Month Costs					
Medicaid Populations	PMPM Trend (in STCs)	Base Year - CY 2018 (in STCs)	DY 11 (2019)	DY 12 (2020)	DY 13 (2021)	DY 14 (2022)	DY 15 (2023)
ABD Adults No TPL	4.30%	$3,152	$3,288	$3,429	$3,576	$3,730	$3,891
ABD Adults TPL	4.30%	$3,563	$3,716	$3,876	$4,043	$4,217	$4,398
RIte Care	5.20%	$558	$587	$618	$650	$683	$719
CSHCN	5.00%	$3,273	$3,437	$3,608	$3,789	$3,978	$4,177
Hypothetical MEGs							
217-like Group	3.10%	$4,095	$4,222	$4,353	$4,488	$4,627	$4,770
Family Planning Group	5.30%	$23	$24	$26	$27	$28	$30
Low-Income Adults (Expansion)	5.10%	$945	$993	$1,044	$1,097	$1,153	$1,212

The second component of the budget neutrality limit is the carryforward amount from savings achieved during Demonstration Years 6-10 of the current waiver. Because the current waiver is still in effect and savings are still being accumulated for DY 9 and 10, the total amount of these savings cannot be calculated yet. However, the total budget neutrality savings from DY 6-8 as reported to CMS are $3,292 million, as shown in Table 7.3. Rhode Island projects that at least an additional $1,000 million in budget neutrality savings will be achieved each year in DY 9 and DY10 for a projected total carryforward of $5,292 million.

Table 7.3: Projected Carryforward
$ Millions, source: Budget Neutrality Q1 2017 CMS 64 Report

				Illustrative Estimates	
Estimated Carryforward to renewal	DY 06 (2014)	DY 07 (2015)	DY 08 (2016)	DY 09 (2017)	DY 10 (2018)
Budget Neutrality Variance	$1,001	$1,059	$1,232	$1,000	$1,000
Cumulative Carryover	**$1,001**	**$2,059**	**$3,292**	**$4,292**	**$5,292**

Rhode Island acknowledges that the amount of savings that was carried forward from DY 1-5 will not continue to carryforward into the extension period.

Once a without waiver target is established, budget neutrality requires that the state develop an anticipated "with waiver" forecast. Table 7.4 provides "with waiver" (WW) projections of PMPMs by MEG for the proposed waiver period (CY 2019-2023). These WW projections use a PMPM trend adjustment based on the targeted impact of waiver initiatives by MEG. This waiver initiative trend adjustment is then applied to the WOW PMPM forecasted trend to determine WW forecasted PMPMs by MEG for the extension period. The details of the derivation of the waiver initiative trend adjustment is described in section E below.

Table 7.4: With Waiver Forecast Summary (WW)

				Per Member Per Month Costs					
Medicaid Populations	Starting Pt: WOW PMPM Trend	Trend Adj for Targeted Impact of Waiver Initiatives	With Waiver PMPM Trend	Base Year - CY 2018	DY 11 (2019)	DY 12 (2020)	DY 13 (2021)	DY 14 (2022)	DY 15 (2023)
ABD Adults No TPL	4.30%	-5%	4.1%	$3,152	$3,281	$3,415	$3,554	$3,699	$3,850
ABD Adults TPL	4.30%	-7%	4.0%	$3,563	$3,706	$3,854	$4,009	$4,169	$4,337
RIte Care	5.20%	-3%	5.1%	$558	$586	$616	$647	$680	$714
CSHCN	5.00%	-1%	5.0%	$3,273	$3,435	$3,605	$3,784	$3,971	$4,168
Hypothetical MEGs									
217-like Group	3.10%	-3%	3.0%	$4,095	$4,218	$4,344	$4,474	$4,608	$4,746
Family Planning Group	5.30%	-2%	5.2%	$23	$24	$25	$27	$28	$30
Low-Income Adults (Expansion)	5.10%	-3%	4.9%	$945	$992	$1,041	$1,092	$1,146	$1,203

Note that the Rhode Island's projected with waiver forecast (WW) PMPMs by MEG for the five-year extension period are less than the WOW PMPMs by MEG. This difference captures the projected reduction in cost associated with the Waiver between CY 2019-2023 *vs.* what would have happened absent this waiver over this same period. As demonstrated by this difference, the Waiver 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.

The following sections provide detailed methodology of the development of the Without Waiver and With Waiver forecasts, as well as a projection of the Budget Neutrality Savings expected over the life of the extension period.

D. Methodology used in developing Rhode Island's Without Waiver Forecast/Budget Neutrality Limit (WOW)

The proposed budget neutrality limit consists of 2 components, as mentioned above. The first is the per capita component based on forecasted PMPMs by MEG by year. The second is the aggregate carryforward amount of budget neutrality savings achieved in DY 6-10. The detailed derivation of both components is shown below.

D1. Per Capita Component of Budget Neutrality Limit (WOW forecast)

In the current waiver STCs, the WOW PMPMs by MEG for DY 6-10 are listed in STC 121 for the regular MEGs, in STC 122 for the hypothetical MEGs, and in STC 123 for the New Adult Group (Expansion). This forecast uses DY 10 (CY 2018) as the baseline for the WOW PMPM forecast for this proposed extension.

According to CMS guidance, the WOW trend rate should estimate the cost of Medicaid services absent the Demonstration. Therefore, the baseline PMPMs by MEG are trended forward at the WOW trend rates by MEG that were agreed to for the current waiver period in STCs 121, 122, and 123.

Actual budget neutrality limits will be based on per capita PMPMs. Enrollment levels will clearly impact total expenditures but EOHHS is not at risk for the number of participants in the Demonstration population. However, for purposes of illustration, and in order to present a potential budget neutrality limit in terms of total expenditures, Rhode Island has developed a projection of member months by MEG based on CY 2016 actual member months reported to CMS and simplified member-months trend rate assumptions by MEG. Table 7.5 below combines the WOW forecasted PMPMs by MEG, as shown in Table 7.3 above, with the projected member-months to show total forecasted WOW expenditure for the proposed extension period.

Table 7.5: Forecasted Total WOW Expenditure

		Base Year	Waiver Period				
PMPM	**Trend**	**CY 2018 (1)**	**DY 11 (2019)**	**DY 12 (2020)**	**DY 13 (2021)**	**DY 14 (2022)**	**DY 15 (2023)**
ABD Adults No TPL	4.30%	$3,152	$3,288	$3,429	$3,576	$3,730	$3,891
ABD Adults TPL	4.30%	$3,563	$3,716	$3,876	$4,043	$4,217	$4,398
RIte Care	5.20%	$558	$587	$618	$650	$683	$719
CSHCN	5.00%	$3,273	$3,437	$3,608	$3,789	$3,978	$4,177
217-like Group	3.10%	$4,095	$4,222	$4,353	$4,488	$4,627	$4,770
Family Planning Group	5.30%	$23	$24	$26	$27	$28	$30
Low-Income Adults (Expansion)	5.10%	$945	$993	$1,044	$1,097	$1,153	$1,212

Enrollment - Member Months	**Trend**	**CY 2016 (2)**	**DY 11 (2019)**	**DY 12 (2020)**	**DY 13 (2021)**	**DY 14 (2022)**	**DY 15 (2023)**
ABD Adults No TPL	0%	168,420	168,420	168,420	168,420	168,420	168,420
ABD Adults TPL	2%	387,806	411,543	419,774	428,169	436,733	445,467
RIte Care	5%	1,851,439	2,143,272	2,250,436	2,362,957	2,481,105	2,605,161
CSHCN	0%	140,829	140,829	140,829	140,829	140,829	140,829
217-like Group	5%	44,021	50,960	53,508	56,183	58,992	61,942
Family Planning Group	0%	4,282	4,282	4,282	4,282	4,282	4,282
Low-Income Adults (Expansion)	5%	810,969	938,798	985,738	1,035,025	1,086,776	1,141,115

Total Expenditure $ Millions	**Trend**	**CY 2018**	**DY 11 (2019)**	**DY 12 (2020)**	**DY 13 (2021)**	**DY 14 (2022)**	**DY 15 (2023)**
ABD Adults No TPL		$531	$554	$577	$602	$628	$655
ABD Adults TPL		$1,382	$1,529	$1,627	$1,731	$1,841	$1,959
RIte Care		$1,033	$1,258	$1,390	$1,535	$1,696	$1,873
CSHCN		$461	$484	$508	$534	$560	$588
217-like Group		$180	$215	$233	$252	$273	$295
Family Planning Group		$0	$0	$0	$0	$0	$0
Low-Income Adults (Expansion)		$766	$932	$1,029	$1,136	$1,253	$1,383
Total Expenditure		**$4,353**	**$4,973**	**$5,364**	**$5,790**	**$6,252**	**$6,754**
Total for Period DY 11-15	**$29,133**						

(1) Base year CY 2018 PMPMs from STCs for current waiver

(2) Base year CY 2016 acutal member months from CMS 64 report

As shown in Table 7.5 above, the total forecasted WOW scenario expenditure for the five-year period is $29,133 million.

D2. Carryforward Component of Budget Neutrality Limit

The second component of the budget neutrality limit is the carryforward amount from savings achieved during Demonstration Years 6-10, the current waiver period. For the first three years of the current waiver period (DY 6-8, CY 2014-16), Rhode Island has achieved budget neutrality savings by holding with waiver spending below the without waiver budget neutrality limits established in the waiver agreement. Furthermore, EOHHS expects similar budget neutrality savings will accrue during the remaining 2 years of the current waiver period (DY 9-10, CY 2017-18).

The Budget Neutrality limit for the current waiver - Demonstration Years 6-10 - included $2,787 million in carryforward savings from Demonstration Years 1-5. In accordance with CMS regulations issued in 2016, the amount of carryforward from DY 1-5 will not carry forward into the extension period.

The total budget neutrality savings from DY 6-8 as reported to CMS is $3,292 million, as shown in Table 7.6 below. Because the current waiver is still in effect and savings are still being accumulated for DY 9 and 10, the total amount of the carryforward cannot be precisely calculated. Rhode Island projects that at least an additional $1,000 million in budget neutrality savings will be achieved each year in DY 9 and DY 10. Combined with the $3,292 million experienced for the DY 6-8 period, Rhode Island estimates a total carryforward of $5,292 million.

In summary, the forecasted Budget Neutrality Limit for the proposed extension period will consist of $29,133 million from the per capita component as shown in Table 7.5 and $5,292 million for the carryforward component as shown in Table 7.6, for a projected aggregate Budget Neutrality Limit of $34,425 million.

Table 7.6: Projected Carryforward from Current Waiver Period
$ Millions, source: Budget Neutrality Q1 2017 CMS 64 Report

	Actuals - Reported on CMS 64		
Without Waiver Total Expenditure	**DY 06 (2014)**	**DY 07 (2015)**	**DY 08 (2016)**
ABD Adults No TPL	$549	$511	$488
ABD Adults TPL	$1,081	$1,173	$1,271
RIte Care	$777	$856	$933
CSHCN	$388	$412	$418
TOTAL WOW Expenditure	**$2,796**	**$2,953**	**$3,110**
With Waiver Total Expenditure	**DY 06 (2014)**	**DY 07 (2015)**	**DY 08 (2016)**
ABD Adults No TPL	$411	$396	$540
ABD Adults TPL	$732	$734	$616
RIte Care	$462	$554	$497
CSHCN	$176	$199	$175
Excess Spending Hypotheticals (total to date)			$40
Excess Spending New Adult Group (total to date)			$0
CNOM	$14	$10	$9
TOTAL With Waiver Expenditure	**$1,795**	**$1,894**	**$1,878**
Budget Neutrality Variance	**$1,001**	**$1,059**	**$1,232**
Carryforward from DY 1-5	$2,787		
Cumulative Budget Neutrality Varian	**$3,788**	**$4,846**	**$6,079**

				Illustrative Estimates	
Estimated Carryforward to renewal	**DY 06 (2014)**	**DY 07 (2015)**	**DY 08 (2016)**	**DY 09 (2017)**	**DY 10 (2018)**
Budget Neutrality Variance	$1,001	$1,059	$1,232	$1,000	$1,000
Cumulative Carryover	**$1,001**	**$2,059**	**$3,292**	**$4,292**	**$5,292**

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

The with waiver (WW) forecast was developed by using the WOW forecast as a starting point and applying adjustments for the targeted impact of waiver initiatives.

Overall EOHHS expects that the waiver initiatives will together rebalance Medicaid expenditures, with targeted increases in professional services and home and community based services (HCBS) resulting in reductions in institutional/long term care and hospital services. To model this impact, an adjustment was applied to the WOW PMPM trend rate by MEG. This adjustment decreased the trend rate for long term care and hospital services by 10% and increased the trend rate for professional services by 5%.[47] The adjustment was weighted for each MEG by the breakdown of spending on the three categories of services.

This waiver initiative trend adjustment was then applied to the WOW PMPM forecasted trend to determine WW forecasted PMPM trend by MEG for the extension period. The derivation of the

[47] The long-term care trend adjustment of -10% is a net decrease resulting from an increase in HCBS spend and a decrease in nursing home and other institutional care spend.

adjusted WW PMPM trend rate is shown in Table 7.7 below.

Table 7.7: Derivation of WW Trend Rate

	LTC	HOSP	PROF
Initiative Impact	-10%	-10%	5%

		% of SFY 16 cost				
Medicaid Populations	WOW PMPM Trend	LTC	HOSP	PROF	Adj to Trend	WW PMPM Trend
ABD Adults No TPL	4.3%	31%	36%	33%	-5%	4.1%
ABD Adults TPL	4.3%	75%	4%	21%	-7%	4.0%
RIte Care	5.2%	1%	51%	48%	-3%	5.1%
CSHCN	5.0%	10%	30%	60%	-1%	5.0%
217-like Group	3.1%	82%	2%	15%	-8%	2.9%
Family Planning Group	5.3%	0%	45%	55%	-2%	5.2%
Low-Income Adults (Expansion)	5.1%	2%	52%	47%	-3%	4.9%

Table 7.8 below uses projected member-months for DY 11-15, as calculated for the WOW scenario, and the WW forecasted PMPM trend rate to show the forecasted WW expenditure total over the proposed extension period. Based on these calculations, the total WW expenditure for the proposed extension period will be $28,965 million.

Table 7.8: Forecasted with Waiver Total Expenditure

		Base Year	Waiver Period				
PMPM	Trend	CY 2018 (1)	DY 11 (2019)	DY 12 (2020)	DY 13 (2021)	DY 14 (2022)	DY 15 (2023)
ABD Adults No TPL	4.1%	$3,152	$3,281	$3,415	$3,554	$3,699	$3,850
ABD Adults TPL	4.0%	$3,563	$3,706	$3,854	$4,009	$4,169	$4,337
RIte Care	5.1%	$558	$586	$616	$647	$680	$714
CSHCN	5.0%	$3,273	$3,435	$3,605	$3,784	$3,971	$4,168
217-like Group	2.9%	$4,095	$4,212	$4,333	$4,457	$4,584	$4,716
Family Planning Group	5.2%	$23	$24	$25	$27	$28	$30
Low-Income Adults (Expansion)	4.9%	$945	$992	$1,041	$1,092	$1,146	$1,203

Enrollment - Member Months	Trend	CY 2016 (2)	DY 11 (2019)	DY 12 (2020)	DY 13 (2021)	DY 14 (2022)	DY 15 (2023)
ABD Adults No TPL	0%	168,420	168,420	168,420	168,420	168,420	168,420
ABD Adults TPL	2%	387,806	411,543	419,774	428,169	436,733	445,467
RIte Care	5%	1,851,439	2,143,272	2,250,436	2,362,957	2,481,105	2,605,161
CSHCN	0%	140,829	140,829	140,829	140,829	140,829	140,829
217-like Group	5%	44,021	50,960	53,508	56,183	58,992	61,942
Family Planning Group	0%	4,282	4,282	4,282	4,282	4,282	4,282
Low-Income Adults (Expansion)	5%	810,969	938,798	985,738	1,035,025	1,086,776	1,141,115

Total Expenditure $ Millions	Trend		DY 11 (2019)	DY 12 (2020)	DY 13 (2021)	DY 14 (2022)	DY 15 (2023)
ABD Adults No TPL			$553	$575	$599	$623	$648
ABD Adults TPL			$1,525	$1,618	$1,716	$1,821	$1,932
RIte Care			$1,256	$1,386	$1,529	$1,686	$1,860
CSHCN			$484	$508	$533	$559	$587
217-like Group			$215	$232	$250	$270	$292
Family Planning Group			$0	$0	$0	$0	$0
Low-Income Adults (Expansion)			$931	$1,026	$1,131	$1,246	$1,373
Total Expenditure			**$4,964**	**$5,345**	**$5,758**	**$6,206**	**$6,693**
Total for Period DY 11-15	**$28,965**						

(1) Base year CY 2018 PMPMs from STCs for current waiver

(2) Base year CY 2016 acutal member months from CMS 64 report

F. Projection of Budget Neutrality Savings

The difference in expenditure between the With Waiver projection and the Budget Neutrality Limit for the Regular MEGs equals the projected Budget Neutrality savings. However, the amount of budget neutrality savings will be reduced by a phase-down percentage. After the phase down is applied, the remaining budget neutrality savings will be used to fund Rhode Island's waiver initiative programs, including Costs Not otherwise Matchable (CNOMs) and the Health System Transformation Project (HSTP).

Based CMS Guidelines released in May 2016, the phase down percentage applied depends on the timing of the interventions that have led to the budget neutrality savings. In Rhode Island, the interventions that have led to savings during the Comprehensive Waiver Demonstration are mainly tied to the implementation of managed care. Although Rhode Island initially implemented managed care for select populations and services in the 1990's, additional populations and services were slowly and deliberately transitioned to managed care over the subsequent years.

In SFY 2014, 48% of Medicaid spend was related to managed care and capitation-based spending. By SFY 2015, that ratio increased to 60% of Medicaid spending. Therefore, for the purposes of applying the phasedown percentage, Rhode Island has indicated CY 2014 as the "year of intervention" for managed care because CY 2014 was the first year that the majority of Medicaid spend was through managed care mechanisms.

CMS guidance instructs that the phase down percentage begins at 90% in Year 6 after the year of intervention. With a year of intervention of CY 2014, that results in a 90% phase down applied in CY 2019, or DY 11 of the waiver period. Each following year applies a phase down percentage decreased by 10% each year.

The projected amount of budget neutrality savings available after the phase down percentage has been applied is shown in Table 7.9 below.

Table 7.9: Forecasted Budget Neutrality Savings

Projection of Budget Neutrality Savings

Without Waiver Projected Total Expenditure	DY 11 (2019)	DY 12 (2020)	DY 13 (2021)	DY 14 (2022)	DY 15 (2023)
ABD Adults No TPL	$554	$577	$602	$628	$655
ABD Adults TPL	$1,529	$1,627	$1,731	$1,841	$1,959
RIte Care	$1,258	$1,390	$1,535	$1,696	$1,873
CSHCN	$484	$508	$534	$560	$588
TOTAL WOW Expenditure	**$3,825**	**$4,102**	**$4,402**	**$4,726**	**$5,076**

With Waiver Estimated Total Expenditure	DY 11 (2019)	DY 12 (2020)	DY 13 (2021)	DY 14 (2022)	DY 15 (2023)
ABD Adults No TPL	$553	$575	$599	$623	$648
ABD Adults TPL	$1,525	$1,618	$1,716	$1,821	$1,932
RIte Care	$1,256	$1,386	$1,529	$1,686	$1,860
CSHCN	$484	$508	$533	$559	$587
Waiver Program Spending (CNOM, HSTP, etc)	these amounts to be determined				
TOTAL With Waiver Expenditure	**$3,818**	**$4,087**	**$4,377**	**$4,690**	**$5,027**
Budget Neutrality Variance	$7	$16	$25	$36	$48
Phase down percent	90%	80%	70%	60%	50%
Budget Neutrality Savings after phasedown	**$7**	**$13**	**$18**	**$22**	**$24**
Carryforward from DY 6-10 (projected)	$5,292				
Cumulative BN Savings	**$5,298**	**$5,311**	**$5,329**	**$5,350**	**$5,374**

Based on the projections shown in this section, Rhode Island forecasts a budget neutrality savings over the waiver period of $5,374 Million. This amount exceeds the amount Rhode Island is planning to spend on all waiver initiatives and programs, including CNOMs and HSTP. Therefore, the Demonstration is projected to result in overall savings for the Medicaid program over the life of the Demonstration period and will meet the budget neutrality requirements set by CMS.

Section 8. Current and Proposed Waivers & Expenditure Authority

Current Waivers

EOHHS requests a renewal of all current waivers listed below. A list of new waivers being requested can be found further in this Section.

1. Amount, Duration, and Scope **Section 1902(a)(10)(B)**
To enable EOHHS to vary the amount, duration and scope of services offered to individuals, regardless of eligibility category, by providing additional services to individuals who are enrollees in certain managed care arrangements.

2. Reasonable Promptness **Section 1902(a)(8)**
To enable the state to impose waiting periods for home and community-based services (HCBS) waiver-like long term care services.

3. Comparability of Eligibility Standards **Section 1902(a)(17)**
To permit the state to apply standards different from those specified in the Medicaid state plan for determining eligibility, including, but not limited to, different income counting methods.

4. Freedom of Choice **Section 1902(a)(23)(A)**
To enable the state to restrict freedom of choice of provider for individuals in the Demonstration. No waiver of freedom of choice is authorized for family planning providers.

5. Retroactive Eligibility **Section 1902(a)(34)**
To enable the state to exclude individuals in the Demonstration from receiving coverage for up to 3 months prior to the date that an application for assistance is made.

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

6. Payment for Self-Directed Care **Section 1902(a)(32)**
To permit the state to operate programs for individual beneficiaries to self-direct expenditures for long-term care services.

7. Payment Review **Section 1902(a)(37)(B)**
To the extent that the state would otherwise need to perform prepayment review for expenditures under programs for self-directed care by individual beneficiaries.

8. Proper and Efficient Administration **Section 1902(a)(4)**
To permit the State to enter into contracts with a single Prepaid Ambulatory Health plan (PAHP) for the delivery of dental services under the RIte Smiles Program in § 42 C.F.R. 438.52.

Current Expenditure Authority

EOHHS requests a renewal of all expenditure authorities listed below. A list of new waivers being requested can be found further in this Section.

1. Expenditures Related to Eligibility Expansion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   Expenditures for Comprehensive demonstration beneficiaries who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the Comprehensive demonstration were provided under an HCBS waiver granted to the state under section 1915(c) of the Act. This includes the application of spousal impoverishment eligibility rules.

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

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

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

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

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

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

5. **RIte Share [Budget Services 2].**

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

6. Designated State Health Program (DSHP)

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

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

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

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

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

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

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

   Effective May 1, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental services for non-working disabled adults ages 19-64 eligible for the General Public cash assistance program with incomes above 133 percent of

the FPL, but who do not qualify for disability benefits.

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

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

9. **Expenditures for Healthy Behaviors Incentives.**

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

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

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

Title XIX Requirements Not Applicable to Budget Population 5:

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

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

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

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

To enable Rhode Island to provide a limited benefit package.

CHIP Expenditure Authority

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

Proposed Waiver and Expenditure Authorities

Table 1: List of Requested Waiver and Expenditure Authorities		
Authority Requested	**Waiver Category**	**Statutory/Regulatory Citation**
Streamlining the Process for Collecting Beneficiary Liability to Decrease Provider Burden and Improve Program Integrity	Eligibility	Post Eligibility Treatment of Income 42 CFR 435.725 and 435.726
Medicaid LTSS for Adults with Developmental and Intellectual Disabilities Group Homes	Eligibility	Comparability of Eligibility Standards Section 1902(a)(17)
Facilitating Medicaid Eligibility for Children with Special Needs	Eligibility	Section 1902(r)(2) of the Act
Covering Family Home Visiting Programs to Improve Birth and Early Childhood Outcomes	Benefits	Amount, Duration, and Scope Section 1902(a)(10)(B)
Supporting Home- and Community-Based Therapeutic Services for the Adult Population	Benefits	Amount, Duration, and Scope Section 1902(a)(10)(B)
Enhancing Peer Support Services for Parents and Youth Navigating Behavioral Health Challenges	Benefits	Amount, Duration, and Scope Section 1902(a)(10)(B)
Improving Access to Care for Homebound Individuals	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)
Building Supports for Individuals in a Mental Health or Substance Use Crisis	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)

Table 1: List of Requested Waiver and Expenditure Authorities		
Authority Requested	**Waiver Category**	**Statutory/Regulatory Citation**
Providing Clinical Expertise to Primary Care through Telephonic Psychiatric Consultation	Benefits	Expenditure Authority under 1115(a)(2) of the Act to provide reimbursement for telephonic psychiatric consultations to primary care providers
Facilitating Successful Transitions to Community Living	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)
Ensuring the Effectiveness of Long-Term Services and Supports	Benefits	Expenditure Authority under 1115(a)(2) of the Act to provide LTC services for individuals who self-attest to financial eligibility factors.
Modernizing the Preventive and Core Home- and Community-Based Services Benefit Package	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B) and 1915(c)
DSHP Claiming and Expenditure Authority for a Full Five Years	Delivery System and Expenditure Authority	Expenditure Authority under 1115(a)(2) of the Act for state expenditures for designated state health programs
Piloting Dental Case Management	Delivery System	Amount, Duration, and Scope Section 1902(a)(10)(B)
Promoting Access to Appropriate, High-Quality Mental Health and Substance Use Treatment by Waiving the IMD Exclusion	Delivery System	Section 1905(a)(29)(B) of the and 42 CFR 435.1009
Testing New Personal Care and Homemaker Services Payment Methodologies Aimed at Increasing Provider Accountability	Finance and Expenditure Authority	Section 1902(a)(23)(A) of the Act

Section 9. Public Notice

EOHHS initiated public discussion of this request at the EOHHS Taskforce meeting in August 2017 by presenting background on the state's 1115 Demonstration Waiver, an update on the anticipated timeline for submission of the request, and an overview of the intended stakeholder input process. The discussion continued during monthly Taskforce meetings with updates on the state's progress and opportunity for stakeholders to ask questions and provide input.

In November 2017 EOHHS held four (4) public input sessions, each session focused on one area of interest including behavioral health, children and families, developmental disabilities, and long-term care. In accordance with the RIGL 42-46 Open Meetings Act, the sessions were open to the public and agendas, meeting materials, and minutes were posted to the Rhode Island Secretary of State website. The following items were included in the agenda for each session:

- Purpose and goals
- Feedback on proposed ideas
- Open discussion on new ideas
- Next steps

Following extensive internal discussion and review, in February 2018, EOHHS posted written responses to the public input that was received from August 2017 through January 2018. EOHHS also presented an overview of the near final list of waivers to be included in the extension request at the February 2018 EOHHS Taskforce meeting and the RI Medicaid Medical Care Advisory Committee (MCAC) meeting.

All materials have been made available on the following EOHHS webpage that is dedicated to the 1115 Waiver Demonstration Extension:
http://www.eohhs.ri.gov/ReferenceCenter/MedicaidStatePlanand1115Waiver/WaiverExtension.aspx

Attachment A: 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 B: Core and Preventive Home and Community Based Services Definitions

CORE SERVICES:

Adult Companion Services
Non-medical care, supervision, and socialization, provided to a functionally impaired adult. Companions may assist or supervise the beneficiary 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 that are incidental to the care and supervision of the beneficiary. This service is provided in accordance with a therapeutic goal in the service plan.

Assisted Living Services
Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to HCBS beneficiaries who reside in a setting that meets the HCBS setting requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with the assisted living provider. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not to be made for 24-hour skilled care. Services furnished are required to meet a beneficiary's LTSS needs in a manner that promotes self-reliance, dignity and independence. Services may be provided in settings licensed at various levels that reflect their capacity to provide different kinds of Medicaid services, depending on a beneficiary's level of care needs based on their licensure authority and capacity to provide specific packages of services to Medicaid beneficiaries with varying levels of acuity needs.

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.

Assistive Technology
Assistive technology means an item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of beneficiaries, optimize their health and, promote independence

and self-care. Assistive technology service means a service that directly assists a beneficiary in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:

- The evaluation of the assistive technology needs of a beneficiary, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the beneficiary in the customary environment of the beneficiary;
- Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for beneficiaries;
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
- Training or technical assistance for the beneficiary, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the beneficiary; and
- Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of beneficiaries.

Bereavement Counseling
Counseling provided to the beneficiary and/or family members in order to guide and help them cope with the beneficiary's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the beneficiary and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities and opportunities for dialog offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment, thereby potentially decreasing complications for the family after the child dies. Bereavement counseling is initiated and billed while the child is receiving the HCBS but may continue after the death of the child for a period of up to six months.

Career Planning
Career planning is a person-centered, comprehensive employment planning and support service that provides assistance for HCBS program beneficiaries to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time limited service engaging a beneficiary in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this service is documentation of the beneficiary's stated career objective and a career plan used to guide individual employment support.

Case Management
Services that assist beneficiaries in gaining access to needed HCBS and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Chore Services

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services are provided only when neither the beneficiary nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.

Community-Based Supported Living Arrangements (CSLA)

Enhanced and specialized home and community based services for persons with more intensive LTSS needs provided through Medicaid certified living arrangements – including shared living/adult foster care, and other adult supportive care homes – that are authorized by the state to address high level functional/clinical needs that otherwise would require care in an institutional-setting, such as dementia care, limited skilled nursing care, and health stabilization services. To meet the certification standards to participate in the program set forth in state law, HCBS providers must establish and maintain an acuity-based, tiered service and payment system that ties reimbursements to: beneficiary's clinical/functional level of need; the scope of services and supports provided; and specific quality and outcome measures. Such standards establish the Medicaid state plan and core waiver services that each type of provider must deliver, the range of acuity-based service enhancements that must be made available to beneficiaries with more intensive care needs, and the minimum state licensure and/or certification requirements a provider must meet to participate at each service/payment level. The standards shall also establish any additional requirements, terms, or conditions that a provider must meet to ensure beneficiaries have access to high quality, cost effective care. The total number of individuals receiving the CSLA in a private home of a principal care provider cannot exceed four (4).

Community Transition Services

Community Transitions 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 person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- Services necessary for the individual’s health and safety such as pest eradication and one-time cleaning prior to occupancy;
- Moving expenses;
- Necessary home accessibility adaptations;
- Activities to assess need, arrange for and procure needed resources.
- Storage fees;
- Weather Appropriate Clothing;

- Assistance with obtaining needed items for housing applications (e.g., assistance with obtaining and paying for a birth certificate or a state identification card, transportation to the local Social Security office);
- Short-term assistance with rental costs for people who are at imminent risk of homelessness and are likely to be institutionalized in the absence of safe housing or who are in an institution and are unable to secure new housing without financial assistance (e.g., past due rent with housing agencies); and
- A short-term supply of food when people transition from the nursing facility or the hospital to the community.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Consultative Clinical and Therapeutic Services
Clinical and therapeutic services that assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, and that are not covered by the Medicaid State Plan, and are necessary to improve the individual's independence and inclusion in their community. Consultation activities are provided by professionals including nursing, psychology, nutrition, counseling and behavior management. The service may include assessment, the development of a home treatment/ support plan, training and technical assistance to carry out the plan and monitoring of the individual and the provider in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Day Treatment and Supports
Services that are necessary for the diagnosis or treatment of the individual's mental illness or disability. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization. These services consist of the following elements:

- Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law);
- Occupational therapy, requiring the skills of a qualified occupational therapist;
- Services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness;
- Drugs and biologicals furnished for therapeutic purposes, provided that the medication is not otherwise available under the State Plan or as a Medicare benefit to a beneficiary;
- Individual activity therapies that are not primarily recreational or diversionary,
- Family counseling (the primary purpose of which is treatment of the individual's condition);
- Training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment); and
- Diagnostic services.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Homemaker Services
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.

Home Delivered Meals
The delivery of hot meals and shelf staples to the beneficiary'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 beneficiaries, if applicable.

Home Stabilization
Home Stabilization services are designed to ensure timely access to appropriate, high quality services for individuals who require support to establish or maintain a home, with the goal of promoting successful community living and reducing unnecessary institutionalization, addressing social determinants of health, and promoting a person-centered, holistic approach to care. EOHHS will use the Home Stabilization Certification Standards to certify providers to deliver either time-limited home tenancy teaching services for individuals who require support in obtaining and maintaining a home (Home Tenancy Services), and/or time-limited, one-time home find services to individuals who require support in finding and transitioning to housing (Home Find Services).

Home Tenancy Services include:

- Early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the role, rights, and responsibilities of the landlord and tenant;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords/neighbors to reduce the risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may be jeopardized;
- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continued training in being a good tenant and lease compliance, including on-going support with activities related to household management.

Home Find Services include:

- Conducting tenant screening and housing assessments that identify the participants' preferences and barriers related to successful tenancy;
- Developing an individualized housing support plan based on housing assessment; assisting with the housing application and search process;
- Identifying resources to cover moving and start-up expenses and assist in arranging for and supporting the details of the move;
- Ensuring that the living environment is safe and ready to move-in; and
- Developing a housing support crisis plan.

Individual Directed Goods and Services
Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through this HCBS or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the beneficiary's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the beneficiary's safety in the home environment; AND, the beneficiary does not have the funds to purchase the item or service or the item or service is not available through another source. Individual directed goods and services are purchased from the beneficiary-directed budget. Experimental or prohibited treatments are excluded. Individual directed goods and services must be documented in the service plan.

Integrated Supported Employment
Integrated employment supports are services and training activities provided in regular business and industry settings for persons with disabilities. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supports 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, training and systematic instruction, job coaching, benefits management, transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the HCBS beneficiary to be successful in integrating into the job setting. Supported employment must be provided in a manner that promotes integration into the workplace and interaction between beneficiaries and people without disabilities in those workplaces.

Medication Management/administration
Pharmacologic management including review of medication use, both current and historical, if indicated; evaluation of symptoms being treated, side effects and effectiveness of current medication(s), adjustment of medications if indicated, and prescription, provided by a medical professional practicing within the scope of his or her licensure.

Non-Medical Transportation
Service is offered to enable HCBS beneficiaries to gain access to HCBS and other community services, activities and resources, as specified by the service plan. This service is available in

addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) and does not replace them. Transportation services under the HCBS are offered in accordance with the beneficiary's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Peer Supports
Peer Supports are provided by Peer Support Specialists that bring to the beneficiary a unique vantage point and the skills of lived experiences in either managing a health condition or disability, or in serving as the primary caregiver for a family member with a health condition or disability. This service is intended to provide individuals with a support system to develop and learn healthy living skills, to encourage personal responsibility and self-determination, to link individuals with the tools and education needed to promote their health and wellness (as well as the health and wellness of those that they are caring for, if applicable), and to teach the skills that are necessary to engage and communicate with providers and systems of care. Peer Support Specialists will work under the direction of a licensed health care practitioner or a non-clinical peer support supervisor. In addition to providing wellness supports, the Peer Support Specialists will utilize his or her own experiences to act as a role model, teacher, and guide who both encourages and empowers the beneficiary to succeed in leading a healthy, productive lifestyle.

Personal Care
A range of assistance to enable HCBS beneficiaries to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the beneficiary to perform a task. Personal care services may be provided on an episodic or on a continuing basis and may be provided by a home health aide, personal care attendant, or direct service worker.

Personal Emergency Response System (PERS)
PERS is an electronic device that enables HCBS beneficiaries to secure help in an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the beneficiary's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein.

Prevocational Services
Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process, to be reviewed not less than annually or more frequently as requested by the individual. Individuals receiving prevocational services must have employment-related goals in their person-centered service plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the successful outcome of prevocational services.

Prevocational services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training. Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services provided under the HCBS.

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. These services are provided to a beneficiary at home.

Psychosocial Rehabilitation Services
Medical or remedial services recommended by a physician or other licensed practitioner of the healing arts under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- Restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- Social skills training in appropriate use of community services;
- Development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention rather than diversion); and,
- Telephone monitoring and counseling services.

The following are specifically excluded from payment for psychosocial rehabilitation services:

- Vocational services,
- Prevocational services,
- Supported employment services, and
- Room and board.

Respite Care
Services provided to beneficiaries, within parameters established by the state, who are unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the beneficiary.

Skilled Nursing
Services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

Specialized Medical Equipment and Supplies
Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable beneficiaries to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the beneficiary to perceive, control, or

communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State Plan that is necessary to address beneficiary functional limitations; and, (e) necessary medical supplies not available under the State Plan. To maximize independence, includes remote devices that enable appropriately licensed health care professionals to monitor certain aspects of a beneficiary's health while remaining at home or in a residential setting. Items reimbursed with HCBS funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design and installation.

Supports for Consumer Direction (Supports Facilitation)
Focuses on empowering beneficiaries to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the beneficiary 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 beneficiary 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.

Training and Counseling Services for Unpaid Caregivers
Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to beneficiaries. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the HCBS. This service may not be provided in order to train paid caregivers. Training includes instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the beneficiary at home. Counseling must be aimed at assisting the unpaid caregiver in meeting and managing the needs of the beneficiary. All training for individuals who provide unpaid support to the beneficiary must be included in the beneficiary's service plan.

PREVENTIVE SERVICES:

Assistive Technology
Assistive technology means an item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of beneficiaries, optimize their health and, promote independence and self-care. Assistive technology service means a service that directly assists a beneficiary in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:

- The evaluation of the assistive technology needs of a beneficiary, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the beneficiary in the customary environment of the beneficiary;
- Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for beneficiaries;

- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
- Training or technical assistance for the beneficiary, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the beneficiary; and
- Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of beneficiaries.

Chore Services

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services are provided only when neither the beneficiary nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.

Community Transition Services

Community Transitions 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 person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- Moving expenses;
- Necessary home accessibility adaptations;
- Activities to assess need, arrange for and procure needed resources.
- Storage fees;
- Weather Appropriate Clothing;
- Assistance with obtaining needed items for housing applications (e.g., assistance with obtaining and paying for a birth certificate or a state identification card, transportation to the local Social Security office);
- Short-term assistance with rental costs for people who are at imminent risk of homelessness and are likely to be institutionalized in the absence of safe housing or

who are in an institution and are unable to secure new housing without financial assistance (e.g., past due rent with housing agencies); and
- A short-term supply of food when people transition from the nursing facility or the hospital to the community.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Homemaker Services
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.

Home Delivered Meals
The delivery of hot meals and shelf staples to the beneficiary'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 beneficiaries, if applicable.

Home Stabilization
Home Stabilization services are designed to ensure timely access to appropriate, high quality services for individuals who require support to establish or maintain a home, with the goal of promoting successful community living and reducing unnecessary institutionalization, addressing social determinants of health, and promoting a person-centered, holistic approach to care. The State will use the Home Stabilization Certification Standards to certify providers to deliver either time-limited home tenancy teaching services for individuals who require support in obtaining and maintaining a home (Home Tenancy Services), and/or time-limited, one-time home find services to individuals who require support in finding and transitioning to housing (Home Find Services).

Home Tenancy Services include:

- Early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;
- Education and training on the role, rights, and responsibilities of the landlord and tenant;
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;
- Assistance in resolving disputes with landlords/neighbors to reduce the risk of eviction or other adverse action;
- Advocacy and linkage with community resources to prevent eviction when housing is, or may be jeopardized;

- Assistance with the housing recertification process;
- Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and
- Continued training in being a good tenant and lease compliance, including on-going support with activities related to household management.

Home Find Services include:

- Conducting tenant screening and housing assessments that identify the participants' preferences and barriers related to successful tenancy;
- Developing an individualized housing support plan based on housing assessment; assisting with the housing application and search process;
- Identifying resources to cover moving and start-up expenses and assist in arranging for and supporting the details of the move;
- Ensuring that the living environment is safe and ready to move-in; and
- Developing a housing support crisis plan.

Non-Medical Transportation
Service is offered to enable HCBS beneficiaries to gain access to HCBS and other community services, activities and resources, as specified by the service plan. This service is available in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) and does not replace them. Transportation services under the HCBS are offered in accordance with the beneficiary's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Medication Management/administration
Pharmacologic management including review of medication use, both current and historical, if indicated; evaluation of symptoms being treated, side effects and effectiveness of current medication(s), adjustment of medications if indicated, and prescription, provided by a medical professional practicing within the scope of his or her licensure.

Peer Supports
Peer Supports are provided by Peer Support Specialists that bring to the beneficiary a unique vantage point and the skills of lived experiences in either managing a health condition or disability, or in serving as the primary caregiver for a family member with a health condition or disability. This service is intended to provide individuals with a support system to develop and learn healthy living skills, to encourage personal responsibility and self-determination, to link individuals with the tools and education needed to promote their health and wellness (as well as the health and wellness of those that they are caring for, if applicable), and to teach the skills that are necessary to engage and communicate with providers and systems of care. Peer Support Specialists will work under the direction of a licensed health care practitioner or a non-clinical peer support supervisor. In addition to providing wellness supports, the Peer Support Specialists will utilize his or her own experiences to act as a role model, teacher, and guide who both encourages and empowers the beneficiary to succeed in leading a healthy, productive lifestyle.

Personal Care
A range of assistance to enable HCBS beneficiaries to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the beneficiary to perform a task. Personal care services may be provided on an episodic or on a continuing basis and may be provided by a home health aide, personal care attendant, or direct service worker.

Personal Emergency Response System (PERS)
PERS is an electronic device that enables HCBS beneficiaries to secure help in an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the beneficiary's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein.

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 Care
Services provided to beneficiaries, within parameters established by the state, who are unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the beneficiary.

Skilled Nursing
Services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

HABILITATIVE SERVICES:

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

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

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

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

Attachment C: Developmental Disability Level of Care Criteria

Attachment C includes: 1) a matrix that identifies the developmental disability (DD) Tiers or levels of care (LOC), the associated settings for each tier, and the types of services and supports associated with the settings of care for each tier; and 2) a narrative description of the criteria for each Tier/LOC.

DD/ID Needs-Based Service Tier Classifications and Options		
Tier	**Service Options**	**Available Supports**
Tier D and E (Highest): ***Extraordinary Needs***	• Living with family/caregiver • Independent Living • Shared Living • Community Support Residence • Group Home/Specialized Group Home	• Community Residential Support or access to overnight support services • Integrated Employment Supports • Integrated Community and/or Day supports • Transportation
Tier C (Highest): ***Significant Needs***	• Living with family/caregiver • Independent Living • Shared Living • Community Support Residence • Group Home	• Community Residential Support or Access to overnight support services • Integrated Employment Supports • Integrated Community and/or Day supports • Transportation
Tier B (High): ***Moderate Needs***	• Living with family/ caregiver • Independent Living • Shared Living • *Group Home*Group Home	• Access to overnight support services • Integrated Employment supports • Integrated Community and/or Day supports • Transportation
Tier A (High): ***Mild Needs***	• Living with Family/Caregiver • Independent Living • Community Support Residence • **Shared Living • *Group Home	• Access to overnight support services • Integrated Employment supports • Integrated Community and/or Day Supports • Transportation

* Tier A or B individuals will not have access to reside in a Group Home setting unless they have met at least one defined exception.
** Tier A will not have access to reside in a Shared Living setting unless they have met at least one defined exception.

Description of Level of Care (LOC) for Developmental Disability Services

Tier A (**High**)- Qualifying Disability with mild support needs
Tier B (**High**)- Qualifying Disability with moderate support needs
Tier C (**Highest**)- Qualifying Disability with identified medical/behavioral needs requiring significant supports
Tier D (**Highest**)- Qualifying Disability with extraordinary medical issues requiring significant medical supports
Tier E (Highest)- Qualifying Disability with extraordinary behavioral issues requiring significant behavioral supports

Tier A (High): Qualifying Disability with mild support needs
Adults at this level are assessed as having mild support needs. These individuals are capable of managing many aspects of their lives with limited supports and services. These individuals do not receive 24/7 paid supports and have a significant amount of time spent alone and/or with natural unpaid supports and engaging in the community with limited supports and services.

Tier B (High): Qualifying Disability with moderate support needs
Adults at this level require more supports than Tier A, but also receive daily support needs but not 24/7 paid supports. Although these individuals require more support to meet personal needs than those in Tier A, their support needs are still generally minimal in many life areas.

Tier C (High): Qualifying Disability with identified medical/behavioral needs requiring significant supports
Adults at this Tier have profound support needs and are identified with medical/behavioral needs requiring significant supports. Some time may be spent alone, engaging independently in certain community activities and/or with unpaid natural supports.

Tier D (Highest): Qualifying Disability with extraordinary medical issues requiring significant medical supports
Adults at this Tier include persons with the most extensive/complex medical support needs that require nurse management in order to minimize medical risk factors. Maximum assistance with activities of daily living is required to meet their extensive physical support needs and personal hygiene; including lifting/transferring and positioning. Feeding tubes and other feeding supports (e.g. aspiration risk management), oxygen therapy or breathing treatments, suctioning, and seizure management are common as well. Some of these individuals may be medically unstable or receiving hospice services.

Tier E (Highest): Qualifying Disability with extraordinary behavioral issues requiring significant behavioral supports
Adults with extraordinary behavioral issues requiring significant behavioral supports. Adults at this Tier include persons with the most extraordinary behavior support needs. All of these individuals require one-to-one supervision for at least a significant portion of each day. Many individuals in this Tier have a mental health condition in addition to a developmental disability. These individuals would pose a safety risk to themselves and/or the community without continuous support.

Attachment D: Evaluation of the Rhode Island Comprehensive 1115 Waiver Demonstration

Report to the Centers for Medicare and Medicaid Services

Evaluation of the Rhode Island Comprehensive 1115 Waiver Demonstration

December 23, 2013 – December 31, 2018

Submitted by the Rhode Island Executive Office of Health and Human Services

(EOHHS)

Section 1: BACKGROUND ON THE DEMONSTRATION PROJECT

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

CMS initially approved the RI Demonstration in 2009 as the Global Consumer Choice Compact Waiver (Global Waiver). At the time, RI's waiver was unique in the nation for its scope (all Medicaid populations were included), and the flexibility afforded to the state in exchange for operating the program under a fixed, aggregate spending cap.

When EOHHS requested the first Demonstration extension in 2013, the Patient Protection and Affordable Care Act (ACA) of 2010's enactment had significantly changed the health care landscape across the country. In addition to authorizing and financing certain coverage expansions, the ACA created new opportunities and challenges for the EOHHS Medicaid program. The Demonstration extension request approved on December 23, 2013 reflected the state's response to these changing realities as well as the expansion of the state's home and community based services (HCBS), and the conversion from an aggregate cap to a per member per month budget neutrality model. Important demonstration project dates include:

- **Initial Waiver Application Submitted** August 8, 2008
- **Initial Waiver Application Approved** January 16, 2009
- **Demonstration Project Implemented** July 1, 2009
- **Demonstration Expiration Date** December 31, 2013
- **Waiver Extension Submitted** August 15, 2013
- **Waiver Extension Approved** December 23, 2013
- **Demonstration Expiration Date** December 31, 2018

The State implemented the core components of the Demonstration on July 1, 2009, with other Demonstration components phased in over time.

Under the Demonstration, EOHHS operates its entire Medicaid program subject to the financial limitations of the Demonstration project, with the exception of:

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

With those four exceptions, all Medicaid funded services on the continuum of care (from preventive care in the home and community, to care in high-intensity hospital settings, to long-term and end-of life-care) whether furnished under the approved Medicaid State Plan, or in

accordance with waivers or expenditure authorities granted under the Demonstration or otherwise, are subject to the requirements of the Demonstration. EOHHS' previous Section 1115 Demonstration programs, RIte Care and RIte Share, were subsumed under this Demonstration, in addition to the state's previous Section 1915(b) Dental Waiver and the state's previous Section 1915(c) home and community-based services (HCBS) waivers.

This report is the evaluation of the Rhode Island Comprehensive 1115 Waiver Demonstration to accompany EOHHS' 2018 waiver extension request. The report addresses the following topics:

- Demonstration evaluation design;
- Goals and objectives;
- Measure construction; and
- Evaluation results.

Section 2: DEMONSTRATION EVALUATION DESIGN

As required by paragraph 123 of the STCs, EOHHS has separately evaluated components of the Demonstration. The outcomes from each evaluation component have been integrated into one programmatic summary that describes whether EOHHS met the Demonstration goal, with recommendations for future efforts. The evaluation will outline and address evaluation questions for both of the following components:

a) **Rhode Island Comprehensive Demonstration.** The evaluation includes a discussion of the goals, objectives, and evaluation questions specific to the entire demonstration. Further, outcome measures were calculated to evaluate the impact of the demonstration during the period of approval, particularly among the target population. The evaluation addresses the adequacy and appropriateness of the benefit coverage, safety and outcome of the LTC reform and expansion groups, including the extended Family Planning, and Elders 65 and over. Data sources and sampling methodology are discussed.

b) **Focused Evaluations.** The separate components evaluated include: LTC Reform, including the HCBS-like and PACE-like programs;

   i. RIte Care;
   ii. Rite Share;
   iii. 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 kids are in temporary state custody;
      (2) Children with Special Health Care Needs;
      (3) Elders 65 and Over;
      (4) HCBS for Frail Elders, HCBS for adults with disabilities, HCBS for Kids in residential diversion and HCBS for at risk/Medicaid eligible youth;
      (5) Uninsured adults with mental illness/substance abuse problems;
      (6) Coverage of detection and intervention services for at risk young children;
      (7) HIV Services

Section 3: GOALS AND OBJECTIVES

The over-arching goal of the Rhode Island Demonstration is to ensure that every Medicaid beneficiary receives the appropriate service, at the appropriate time, and in the most appropriate (and least restrictive) setting irrespective of age, healthcare needs, or basis of eligibility. These goals align with the Triple Aim objectives of improving patient care and population health while reducing per capita costs. While containing costs is an important component of this goal, it is believed that the improved efficiencies implemented through this Demonstration have enhanced the quality of care provided to all Medicaid beneficiaries and resulted in better outcomes for all recipients. EOHHS has accomplished these goals by using the administrative flexibility afforded in the Demonstration to:

- Operate its Medicaid program more efficiently, through the application of selective contracting strategies, care management systems, and links to "medical homes provided through multiple delivery systems."
- Reform long-term care services and supports for eligible beneficiaries.
- Use Demonstration expenditure authority to assure continuity in Medicaid coverage, transition eligible populations to a QHP and prevent or delay growth in selected populations at risk for Medicaid eligibility.

Several of the major components of the Demonstration were launched on July 1, 2009 (particularly those related to restructuring long-term care services). However, other components continued to be developed during the current Demonstration. Unless otherwise specified, analyses have been constructed with a Demonstration start date of December 23, 2013.

As required under the special terms and conditions (STCs), the evaluation includes two components: 1) addresses the Rhode Island Comprehensive Demonstration as a whole and deals with those components of the Demonstration that impact multiple populations; and 2) focused Evaluations that examine goals and objectives that relate to one or more related Budget Population. Both of these components are included in the measure construction and data analysis. Taken together the components provide CMS and EOHHS with valuable information to identify elements of the Medicaid Program that have been successful in achieving stated goals. It has also provided helpful guidance on how to improve or modify the program going forward.

MEASURE CONSTRUCTION

GOAL 1: CARE MANAGEMENT ASSIGNMENT

Measure 1: Percent enrolled in a managed care organization.

Denominator: Number of people enrolled in each budget population/sub-population as of measurement year.

Numerator: Number of people in each budget population/sub-population enrolled in one of the established managed care plans.

Data Sources: MMIS Eligibility and Enrollment Files.

Measure 2: Percent assigned to a case management system.

Denominator: Number of people enrolled in each budget population/sub-population as of measurement year.

Numerator: Number of people in each budget population/sub-population assigned to one of the enhanced case management programs.

Data Sources: MMIS Eligibility and Enrollment Files.

Measure 3: Percent assigned to one of the 36 primary care medical home sites.

Denominator: Number of people enrolled in each budget population/sub-population as of December 31 of measurement year.

Numerator: Number of people in each budget population/sub-population assigned to one of the 36 established primary care medical home sites.

Data Sources: MMIS Eligibility and Enrollment Files.

Rationale: These measures are designed to assure that all Medicaid members in RI are associated with one of several established care management systems. Each of these systems will be held accountable for the services provided to populations assigned to their care. EOHHS also assessed performance on a variety of parameters to identify model delivery systems for provision of care across the continuum.

GOAL 2: MEANINGFUL PCP ASSIGNMENT

Measure 1: Percent of patients who have an outpatient visit with their assigned primary care provider.

Denominator: Number of people enrolled in each budget population/sub-population as of December 31 of measurement year.

Numerator: Number of people in each budget population/sub-population who had at least one outpatient visit (i.e., CPT code 99201-99215 or 99381-99397) with their assigned/attributed PCP during measurement year.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Rationale: Establishing meaningful PCP contact is an essential component of all care management systems. This measure established benchmarks for EOHHS to track the type of PCP contact that leads to better health outcomes.

GOAL 3: LEVEL OF CARE DETERMINATION VALIDATION

Measure 1: Percent of nursing home residents who score in the 'low care need' group.

Denominator: Medicaid patients with a paid nursing home claim during the measurement year.

Numerator: Low level of care is defined as patients who require no physical assistance in any of the four late-loss ADLs (i.e., bed mobility, transferring, toileting and eating) and are not classified with "Special Rehab" or "Clinically Complex RUG-III scores. **(**see, Ikegami, et al., "Low-Care Cases in Long-Term Care Settings: Variation among Nations," *Age and Ageing* 26, no. 2 Supp. (1997): 67–71).
Data Sources: RI EOHHS Data Warehouse: ADL, IADL, RUG Scores.

Measure 2: Comparison of critical incident rates (ED, inpatient admissions, inpatient days and falls) by budget population/sub-population.

Denominator: Medicaid population that qualifies for Long-term Services and Supports (LTSS) by budget population/sub-population: Unique members and total member months in each sub-population.
Numerator: Number ED visits, inpatient admissions and total inpatient days. Reported number of falls among nursing home patients.
Data Sources: RI EOHHS Data Warehouse Level of Care Determination File. MMIS Eligibility/Enrollment Files as well as Claims-based MC837 and FFS837 claims. Falls assessed from Nursing Home Incident Reports

Rationale: Attempts to re-balance LTSS are based on the assumption that there are beneficiaries in nursing homes who could be more effectively treated in the community at a lower cost. These measures identified the nursing home population likely to benefit from community services and assess whether transitions lead to bettered outcomes. Nursing home residents with a low level of need ought to be tracked to identify the circumstances keeping them in nursing homes and, when possible, identify alternative care plans.

GOAL 4: ASSESSMENT OF LTSS/HCBS

Measure 1: Transitions from nursing homes to community

Denominator: Medicaid patients in the Money Follows the Person Program (MFP) with a paid nursing home claim during the measurement year.
Numerator: Patient in the MFP program who are discharged from the Nursing Home who qualify for home and community-based services.
Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Measure 2: Re-admission to nursing home within first year of transition to community.

Denominator: Medicaid population in the MFP program that transitioned from nursing home to home and community-based services.
Numerator: Number of Medicaid members in the MFP program who were readmitted to nursing home during first year in transition.
Data Sources: MMIS Eligibility/Enrollment Files as well as Claims-based MC837 and FFS837 claims.

Measure 3: Re-balancing Population: Characteristics of the HCBS Populations:

Denominator: Medicaid population who qualify for HCBS during the measurement year.

Numerator: Total Medicaid members receiving HCBS by program.

Data Sources: RI EOHHS Data Warehouse.

MMIS Eligibility/Enrollment Files as well as Claims-based MC837 and FFS837 claims.

Rationale: Reasonable re-balancing efforts need to monitor HCBS and transitions from nursing homes to community settings, and assure that beneficiaries are held harmless in the process. The effectiveness of these services should bend the cost curse in a favorable direction.

GOAL 5: UTILIZATION OF SERVICES ASSESSMENT

Measure 1: Annual Routine Physical Exam/1,000

Denominator: Number of people enrolled in each budget population/sub-population as of December 31 of measurement year: Unduplicated count of people and member months.

Numerator: Number of outpatient claims billed with a CPT code between 99381 and 99397.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Measure 2: Annual ED visit/1,000

Denominator: Number of people enrolled in each budget population/sub-population as of December 31 of measurement year: Unduplicated count of people and member months.

Numerator: Number of ED visits with a primary diagnosis code identified on the State's list of ambulatory care sensitive conditions.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Measure 3: Follow-up within 7 days after a behavioral health discharge

Denominator: Discharges from acute care hospitals during the measurement year with a primary diagnosis between 290.xx and 314.xx.

Numerator: Any outpatient follow-up visit within 7 days of discharge. (Outpatient visits include PCP, Specialist and Behavioral Health Counseling).

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Measure 4: Inpatient readmission rate within 30 days

Denominator: Discharges from acute care hospitals during the measurement year.

Numerator: Readmission to an acute care inpatient hospital for any reason within 30 days of discharge.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Rationale: An important objective of the Demonstration is to ensure access to care across the continuum among all Medicaid populations regardless of delivery system or basis of eligibility. Comparison of these rates with national benchmarks help assess adequacy of services. Comparability among all RI Medicaid populations on these rates were viewed as evidence of balance among the various delivery systems. Alternatively, noticeable variations among these services were viewed as discordant delivery requiring further investigation.

GOAL 6: POPULATIONS

Measure 1: Monitor distribution of Medicaid Population by Budget Population/Sub-population

Operational definition: These are the populations monitored in Table 13 and identify the care management systems offered to each person enrolled in Medicaid. It is important that we monitor these populations on a periodic basis to be sure that no one is slipping through the cracks.

Data Sources: MMIS Eligibility/Enrollment Files.

Rationale: While assessing the care management systems of members enrolled in a formal or established care management system, members who opted-out of managed care arrangements or received care through existing fee-for-service delivery systems are closely monitored.

GOAL 7: TRANSITIONS TO ACA

Measure 1: Percent of Medicaid members continuously enrolled.

Denominator: Total Monthly Enrollment in Medicaid.

Numerator: Number of Medicaid members who have been continuously enrolled each of the past 12 months.

Data Sources: MMIS Eligibility/Enrollment Files.

Measure 1: Percent of Medicaid members with out-of-plan benefits.

Denominator: Total Enrollment in Medicaid.

Numerator: Number of Medicaid members with paid claims for out-of-plan services

Data Sources: MMIS Eligibility/Enrollment Files linked to MC837 and FFS837 claims.

Rationale: The ACA changed eligibility requirements for many Medicaid populations. EOHHS needs to ensure that those who lost coverage due to the ACA have successfully transitioned to plans under the ACA.

Section 4: EVALUATION RESULTS

GOAL 1: CARE MANAGEMENT ASSIGNMENT

An objective of the Demonstration was to shift enrollment from the Fee-for-Service (FFS) delivery system to the Managed Care Organizations (MCO), to both assist in effectively managing members' healthcare and maintain costs. Chart 4.1 and Chart 4.2 below show that the number of members in FFS decreased 65% from CY14 to CY15 and 18% through 2016.

Chart 4.1: Care Management Assignment Change by Number of Unique Members by Population.

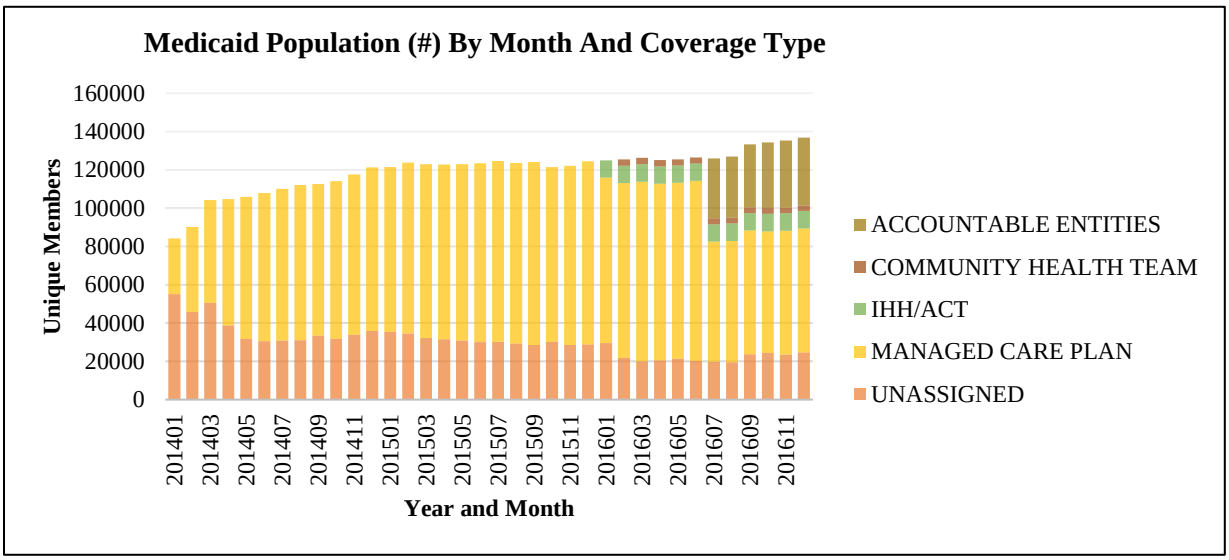


Chart 4.2: Care Management Assignment by Percent by Coverage Type.

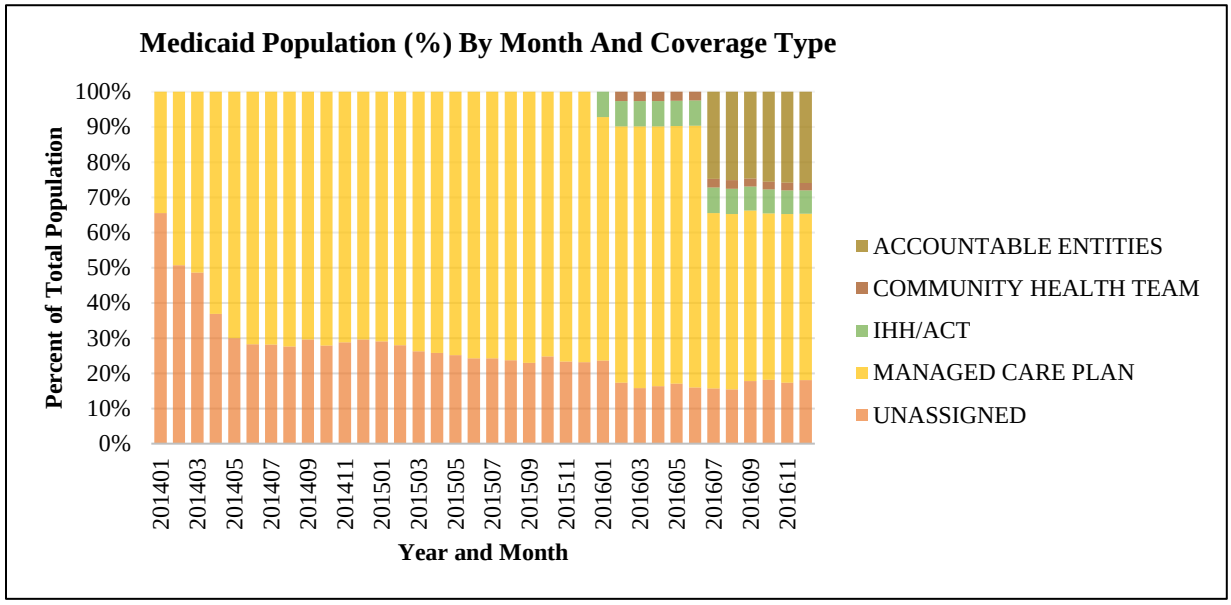


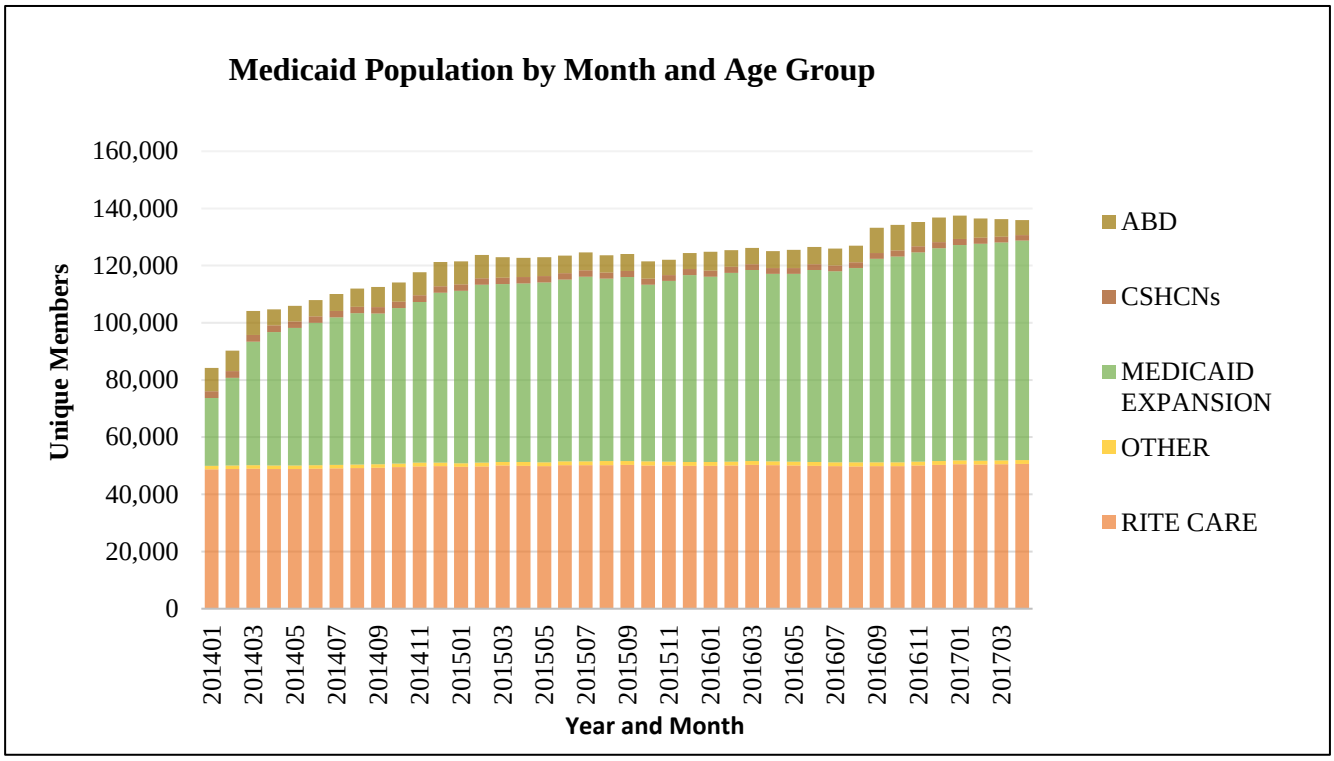
Table 4.1 and Chart 4.3 below include details that break out the above populations. In CY 2016, several new initiatives were implemented including, Integrated Health Homes/Assertive Community Treatment (IHH/ACT), Community Health Teams (CHTs), and Accountable Entities (AE's). These initiatives added to EOHHS's ability to assist Rhode Islanders with managing their health care needs. These programs were also the vehicle used to transition Medicaid members with complex healthcare needs out of FFS and into integrated programs within the managed care delivery system. Table 4.1 shows the number of unique members in IHH/ACT, CHT, and AE's since their inception.

Table 4.1: Care Management Assignment across new Initiatives.

Initiative	# of Unique Members		
	2016	**2017**	**Total**
IHH/ACT	11,689	9,840	21,529
CHT	3,337	2,842	6,179
AE	41,901	N/A	41,901

Chart 4.3 represents another view of care management broken out by populations.

Chart 4.3: Care Management Assignment by Aid Group.



GOAL 2: MEANINGFUL PCP ASSIGNMENT

Table 4.2 is intended to assure that all populations have meaningful PCP assignments; defined as having a primary care physician of record and having received medical care from the assigned PCP. Everyone who has an assigned PCP has a visit on record (see Table 4.3). However, the Rite Care and Expansion groups, two of our largest populations, have experienced a decrease of PCP assignment over the three-year period. This is an opportunity for further analysis to determine root cause and potential interventions. Data shows that PCP involvement increases overall health management and outcomes.

Table 4.2: PCP Assignment Percent of Change by Population.

	2014	2015	2016	% Change 2014 – 2016	% Change 2015 – 2016
RC	80.27	69.76	74.2	-8%	6%
EXP	95.4	91.1	88.5	-7%	-3%
ABD	74	78.2	83.6	13%	7%
CSHCN	89	85.6	87.8	-1%	3%
Other	74.8	77.3	79.9	7%	3%

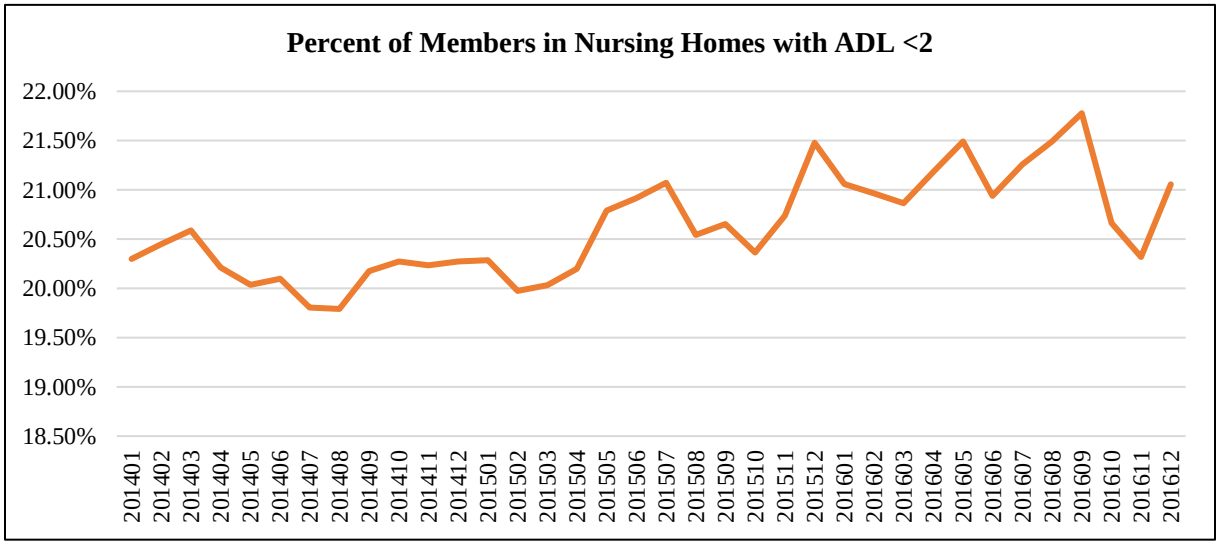
Table 4.3: PCP Visit Percent of Change by Population.

	2014	2015	2016	% Change 2014 – 2016	% Change 2015 – 2016
RC	97.6	98.7	98.7	1%	0%
EXP	95.7	96.6	97.4	2%	1%
ABD	90.1	92.3	93.1	3%	1%
CSHCN	98.3	98.7	98.8	1%	0%
Other	94.7	96.7	97.4	3%	1%

GOAL 3: LEVEL OF CARE DETERMINATION VALIDATION

Only individuals designated as "high care need" should qualify for admission to a nursing home under the reinvented Medicaid. Need is determined based on the Activities of Daily Living Score (ADL); individuals with an ADL of less than 2 are considered the "low care need" and as such could be candidates for transition from institutional support to more community-based services. Chart 4.4 shows that from CY 2014 through CY 2016, approximately 20% of members in nursing homes had an ADL of less than 2.

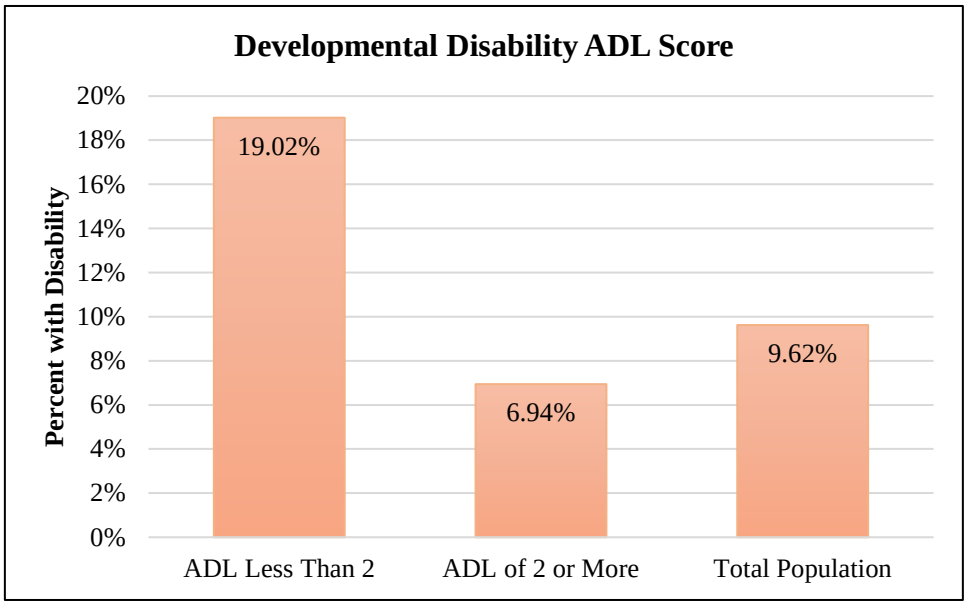
Chart 4: Percent of Members in Nursing Homes with ADL <2



To further understand this population, EOHHS has begun to analyze individuals, including both new entrants and individuals already in institutional settings, with an ADL score of less than 2. The analyses revealed that although these members do score as "low care" need in terms of ADL's, 19% have a developmental disability that is likely the cause of their institutionalization. In fact, when comparing those with ADL less than 2 to those with ADL of 2 or more, there is a significant difference in the percent with a developmental disability (See Chart 4.5 below). Future analysis will include investigating the remainder of the nursing home residents with an ADL score of less

than 2 to understand the potential for transitioning these members out of the nursing home and back into the community with appropriate services in place.

Chart 4.5: Comparison of Individuals with a Developmental Disability by ADL Score



Critical incidents such as inpatient stays and ED visits are important metrics to track on all LTC members. These metrics are also important to compare residents in nursing homes with those in HCBS settings. Table 4.4 shows the number of unique individuals with a critical incident (at least one) and the number of critical events that occurred by year. Table 4.5 shows the number of incidents by incident type by year. Data is from Money Follows the Person (MFP) and Nursing Home Transition Program (NHTP) enrollees only and does not cover the entire long-term care Medicaid population. Additional individuals may have been transitioned without these formal programs. Though it appears that there has been no change in critical events, this is a rather small sample size, so any changes over time are not necessarily indicative of the entire population. However, the types of critical incidents of note are hospitalizations and ED visits. Expanding the tracking of critical incidents among a larger Medicaid LTC population could assist in identifying needs and future interventions.

Table 4.4: Number of Unique Individuals with a Critical Incident and Number of Critical Incidents Each Year.

Critical Incidents (By Number)

Year	# of Unique Individuals w/at least 1 Event	# of Unique Individuals w/ >1 Event	# of Critical Events
2014	48	23	94
2015	45	14	101
2016	46	32	118
2017*	11	11	26
Grand Total	**150**	**80**	**339**

**2017 is not complete data.*

Table 4.5: Number of Incidents by Type (Some events have more than one incident type)

Year	Abuse	Attempted suicide	Criminal justice system	Death	ER Visit	Exploitation	Hospitalization	Medication error	Missing person	Natural disaster	Neglect	Other	Totals
2014	4	1	1	5	35	2	51	1	0	0	1	11	**112**
2015	1	0	0	10	27	0	69	0	0	0	1	9	**117**
2016	0	0	0	6	35	0	65	0	0	0	0	19	**125**
2017	1	0	0	1	4	0	10	0	1	0	1	6	**24**
Grand Total	**6**	**1**	**1**	**22**	**101**	**2**	**195**	**1**	**1**	**0**	**3**	**45**	**378**

GOAL 4: ASSESSMENT OF LTSS/HCBS

It is also of great importance to examine successful transitions from a nursing home. Table 4.6 shows transitions, by year, among nursing home members of all ages. Table 4.7 shows transitions, by year, among nursing home residents ages 65 years and older. While 2% to 3% of have been successfully transitioned from 2014 to 2016, it is important to again note the small sample size. If these results could be expanded to a larger LTC Medicaid population, these results would be more meaningful.

Table 4.6: Transitions of Nursing Home Members (all ages)

Nursing Home Transitions (All Ages)

	All Transitions	FTEs in Custodial NH	% Transitioned of FTEs in Custodial NH
2014	120	4,341	2.8%
2015	109	4,176	2.6%
2016	87	3,739	2.3%
2017 YTD	27	2,642	1.0%
Totals	**343**		

Table 4.7: Transitions of Nursing Home Members (65 years and over)

Nursing home Transitions (Ages 65+)

	All Transitions	FTEs in Custodial NH	% Transitioned of FTEs in Custodial NH
2014	67	3,930	1.7%
2015	67	3,753	1.8%
2016	47	3,350	1.4%
2017 YTD	17	2,386	0.7%
Totals	**198**		

EOHHS has pulled together an internal team comprised of program, policy, and analytic staff to identify specific programs within the HCBS umbrella to better understand the specific needs of the population. Rebalancing efforts are increasingly focused on supporting members with an array of services that allow them to safely remain in the community. Table 4.8 shows the number of unique members in each HCBS program by calendar year. These data provide a baseline from which EOHHS will continually monitor and adjust programs and services to ensure members who reside in the community have the supports they need to remain there.

Table 4.8: Number of Unique Members in Each HCBS Program by Calendar Year

Individuals Enrolled in HCBS Programs

Calendar Year	HCBS - Adult Day	HCBS - Core Community Services	HCBS - DEA Assisted Living	HCBS - DEA Community Services	HCBS - Habilitation Community Services	HCBS - Habilitation Group Homes	HCBS - Personal Choice	HCBS - Preventive Community Services	HCBS - RI Housing Assisted Living	HCBS - Shared Living	HCBS - Unique Count	HCBS - Population
2014	1529	2555	489	601	22	24	553	892	150	128	6355	5459
2015	1716	2651	579	670	22	25	566	911	171	141	6839	5851
2016	1807	2622	602	673	23	26	554	904	171	139	6894	5901
2017	1609	2060	448	536	22	21	421	764	141	97	5565	4831

GOAL 5: UTILIZATION OF SERVICES ASSESSMENT

One of the best ways to assure parity in access to essential services is to track utilization rates across populations. Significant variation can suggest issues with access to important services that may need to be further investigated. Tables 4.9 through 4.12 show the percent of change in utilization by population. Overall, there has been an increase in PCP visits except for the Expansion and At-Risk Youth populations. Newly enrolled Expansion members show a high rate of PCP visits as they have initial access to health care benefits. However, over time, continuously enrolled expansion members appear to decrease their PCP visits. The decrease in PCP visit rate among At-Risk Youth has decreased significantly. Although this is a very small population, the threat of these fragile youth falling through the cracks is high. Further analysis is required to determine root cause that will highlight areas for program improvement.

Table 4.9: PCP Utilization Percent Change by Population.

PCP Visits/1000

	2014	2015	2016	2017	% Change CY14 - CY16	% Change CY15 - CY16
ABD	3,101	3,671	3,801	2,609	23%	4%
CSHCNs	2,810	2,955	3,137	3,149	12%	6%
EFP	432	823	443	140	2%	-46%
Elders 65+	147	184	137	41	-7%	-26%
Expansion	3,186	2,965	2,764	2,528	-13%	-7%
Other	189	232	268	240	41%	15%
RIte Care	2,784	2,896	2,808	2,670	1%	-3%
Youth at Risk	440	277	167	24	-62%	-40%
Total	**2,676**	**2,816**	**2,753**	**2,441**	**3%**	**-2%**

ED utilization rates are driven by patient morbidity and access to primary care (See Table 4.10). Complex patients who are poorly managed generally have higher ED utilization rates as do otherwise healthy populations with poor or obstructed access to primary care. Comparisons among populations tend to confirm these assumptions.

These data suggest that consistent progress in reducing ED visits is being made in all but one population - CSHCNs. As expected, ABD adults (which include the most complex cases) have the highest ED utilization rate and the lowest percent decrease between CY 2014 and 2016. The elevated rate in the Expansion population in CY 2014 is likely due to initial problems in connecting with their PCP. It is encouraging to see the rate decrease year-over-year through 2016. Similarly, decreased rates in the RIte Care program are also encouraging. Rates in the Elders 65+ seem low but this population will be followed more closely in the future.

Table 4.10: ED Visits Utilization Percent Change by Population.

ED Visits/1000

	2014	2015	2016	2017	% Change CY14 - CY16	% Change CY15 - CY16
ABD	1,067	1,031	1,006	739	-6%	-2%
CSHCNs	639	613	594	614	-7%	-3%
EFP	386	614	271	25	-30%	-56%
Elders 65+	124	122	111	85	-11%	-10%
Expansion	799	709	699	593	-13%	-1%
Other	113	119	126	99	11%	6%
RIte Care	573	553	542	514	-5%	-2%
Youth at Risk	70	28	22	2	-68%	-21%
Total	**661**	**632**	**618**	**535**	-7%	-2%

Table 4.11 tracks inpatient utilization rates by year and population. Overall, our inpatient utilization has remained fairly constant since 2014 with some notable variances. Rates in the Expansion population decreased significantly between 2014 and 2015 but it is suspected that that is evidence of demand among people previously uninsured. Rates among the EFP population varied inconsistently; it is suspected that that is due to the small sample size for that population.

Table 4.11: IP Utilization Percent Change by Population.

IP Admits/1000

	2014	2015	2016	2017	% Change CY14 - CY16	% Change CY15 - CY16
ABD	229	249	232	161	1%	-7%
CSHCNs	129	154	142	135	10%	-8%
EFP	76	522	266	241	250%	-49%
Elders 65+	41	44	41	28	0%	-7%
Expansion	127	109	109	79	-14%	0%
Other	17	30	38	14	122%	26%
RIte Care	58	93	79	61	36%	-15%
Youth at Risk	3	6	4	0	32%	-36%
Total	**100**	**120**	**109**	**80**	9%	-9%

Table 4.12: Readmission within 30 Days of Discharge by Population

Readmissions within 30 Days by Population

	CY 2014	CY 2015					CY 2016			CY 2017 (yr to date)				
	Admissions	Readmissions	Rate	Admissions	Readmissions	Rate	Admissions	Readmissions	Rate	Admissions	Readmissions	Rate	% Change 2014 to 2017	% Change 2016 to 2017
ABD	12,763	2,205	20.9%	12,788	2,237	21.2%	11,967	1,983	19.9%	2,058	276	15.5%	-26%	-22%
Non-working Adults	0	0	0.0%			0.0%			0.0%			0.0%	N/A	N/A
Adults at Risk for LTC	0	0	0.0%			0.0%			0.0%			0.0%	N/A	N/A
Adults (MH_Uninsured)	0	0	0.0%			0.0%			0.0%			0.0%	N/A	N/A
CSHCN	1,941	285	17.2%	1,896	286	17.8%	1,721	237	16.0%	412	44	12.0%	-31%	-25%
EFP	34	1	3.0%	125	2	1.6%	113	1	0.9%	19	1	5.6%	83%	522%
Elders 65 and Over	241	12	5.2%	286	36	14.4%	274	42	18.1%	49	3	6.5%	24%	-64%
Medicaid Expansion	6,333	775	13.9%	7,123	886	14.2%	7,709	1,156	17.6%	1,513	124	8.9%	-36%	-49%
Other	408	48	13.3%	505	60	13.5%	646	60	10.2%	59	0	0.0%	-100%	-100%
RIte Care	13,734	629	4.8%	14,044	640	4.8%	12,489	687	5.8%	2,535	100	4.1%	-14%	-29%
Youth at Risk	18	0	0.0%	17	1	100.0%	12	3	300.0%	0	0	0.0%	N/A	N/A
Total	**35,472**	**3,955**	**12.5%**	**36,784**	**4,148**	**12.7%**	**34,931**	**4,169**	**13.6%**	**6,645**	**548**	**9.0%**	-28%	-34%

GOAL 6: POPULATIONS

To further evaluate the Medicaid populations in care management, and to assure that all Medicaid members have been assigned to an appropriate level of care management, unique members across budget populations were examined overtime (CY14 to CY17). The data in Table 4.13 show decreases in Elders 65 +, Other (see definitions in Attachment 1), and ABD populations, and increases in Medicaid Expansion, Adults at Risk, and Children at Risk. The decreases are likely due to challenges with EOHHS's new unified enrollment system, and members becoming dually-eligible. The increases, specifically with Medicaid Expansion, are a direct result of the ACA. Medicaid Expansion began in late 2013 and the population has grown from approximately 23,700 in 2014 to 76,700 through March of 2017. This is a population that could receive healthcare through the ACA. The addition of the Expansion population and the increase in this population over time has allowed more Rhode Islanders to received managed health care. The increase in adults at risk of LTC illustrates EOHHS's success in identifying them and ensuring they remain in the community as long as they remain safe. Similarly, the increase in the population of children at risk shows EOHH's success in identifying children at need of supportive services to prevent them from becoming Medicaid eligible.

Table 4.13: Average Number of Unique Members by Calendar Year

Average # Unique Members by CY

Population	2014	2015	2016	2017*	% Change CY14 - CY17	% Change CY16 - CY17
ABD	45,382	46,388	45,096	40,441	-12%	-12%
AD Non-Working	17	N/A	N/A	N/A	N/A	N/A
Adults at Risk for LTC	2,295	2,541	2,704	2,837	19%	5%
Adults with Mental Illness w/o insurance	11,401	10,945	11,027	10,836	-5%	-2%
CSHCNs	11,397	11,463	10,761	10,334	-10%	-4%
EFP	150	50**	174	154	3%	-13%
Elders65+	5,103	5,252	4,868	3,734	-37%	-30%
Medicaid Expansion	47,169	62,352	67,747	75,678	38%	10%
Other	13,141	12,664	12,245	11,283	-16%	-9%
Rite Care	133,173	140,743	147,322	157,638	16%	7%
Kids at Risk for Medicaid	2,534	2,723	3,045	3,665	31%	17%

*CY2017 data is thru April 30, 2017 **

GOAL 7: TRANSITIONS TO ACA

Tracking continuity of enrollment in Medicaid is an important function in monitoring continuity of care resulting from the ACA. Table 4.14 shows continuous enrollment among populations from CY14 to CY16. With the introduction of the ACA, members continuously enrolled in CY 2014 was under 50%. This has increased 55% from CY2014 to CY2016. In comparison, the majority of members in population groups *Adults at Risk for LTC* and *Adults with Mental Illness* were continuously enrolled from 2014 through 2016, and two thirds of members in population groups *ABD*, *CSHCN*, and *RIte Care* were continuously enrolled during the same period.

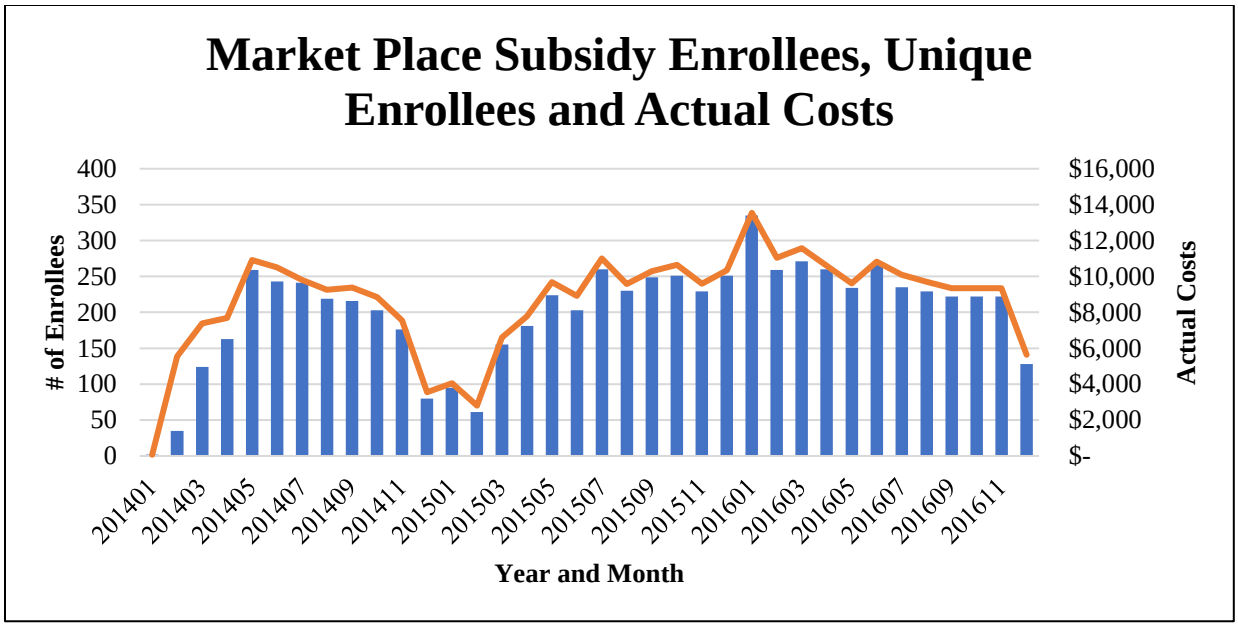
Table 4.14: Change in % Members Continuously Enrolled CY14 through CY16 by Population

Population	2014	2015	2016	% Change CY14 - CY16	% Change CY15 - CY16
ABD	79.18%	79.47%	82.08%	4%	3%
AD Non-Working	N/A	N/A	N/A	N/A	N/A
Adults at Risk for LTC	91.73%	94.58%	95.76%	4%	1%
Adults with Mental Illness w/o insurance	96.85%	100.00%	100.00%	3%	0%
CSHCNs	74.47%	73.40%	73.49%	-1%	0%
EFP*	--	--	--	--	--
Elders65+	58.39%	53.08%	56.32%	-4%	6%
Medicaid Expansion	41.57%	60.07%	64.23%	55%	7%
Other	50.33%	54.03%	54.34%	8%	1%
Rite Care	64.16%	72.00%	75.31%	17%	5%
Kids at Risk for Medicaid	33.87%	36.92%	46.44%	37%	26%

***** *EFP population size is not large enough to determine trends.*

As discussed above, Medicaid Expansion members are increasingly and continuously enrolled, suggesting continuity of care has been maintained within the managed care system. Premium assistance members, including parents/caretaker of Medicaid eligible children in households with incomes between 142% and 179% of the Federal Poverty Level (FPL) who previously could not access care, have been enrolled in a Qualified Health Plan (QHP) through HealthSource RI. Chart 4.6 below shows that EOHHS has consistently enrolled these members since implementation of the ACA. Because cost trends are directly related to enrollment trends, costs have remained consistent during the CY2014 through CY2016 time period.

Chart 4.6: Market Place Subsidy Enrollees, Unique Enrollees and Actual Costs


Market Place Subsidy Enrollees, Unique Enrollees and Actual Costs
400
350
300
250
200
150
100
50
0
# of Enrollees
$16,000
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
Actual Costs
201401
201403
201405
201407
201409
201411
201501
201503
201505
201507
201509
201511
201601
201603
201605
201607
201609
201611
Year and Month

Attachment 1: AID CATEGORIES INCLUDED IN 'OTHER' WAIVER POPULATION

The 'Other' waiver population referenced in Section 4: Evaluation Results, Goal 6: Populations is composed of the following Aid Categories.

Cat Needy Alien Emg. Only / Aged
Cat Needy Alien Emg. Only / Disabled
Cat Needy Cash Assist / Disabled
Cat Needy Home Comm Base Svc / Aged
Cat Needy Home Comm Base Svc / Disabled
Cat Needy Medical Asst Eligible / Aged
Cat Needy Medical Asst Eligible / Disabled
Cat Needy No Cash Assist / Disabled Adult
Former Foster Child
MA Expansion Adult w/o Dependent Child, LE 133%
Med Needy Alien Emg Only / Aged
Med Needy Individual / Aged
Med Needy Individual / Disabled
Postpartum Woman Ext FP MA ineligible Alien 250%<Income<350% of FPL
Postpartum Woman Ext FP MA ineligible Alien Income<185% of FPL
Postpartum Woman Ext FP, Federally ineligible, 185% - 250% of FPL
QUALIFYING INDIVIDUALS 1
RIPAE Copay Level 1 8018 - 60/40 COPAY
RIPAE Copay Level 2 8019 - 30/70 COPAY
RIPAE Copay Level 3 8020 - 15/85 COPAY
RIPAE Copay Level 4 8021 - 15/85 COPAY
Rite Care Post-Partum Woman Ext. FP 250%<Income<350% of FPL
Special Adolescent - state only program

Attachment E: Quality Monitoring and External Quality Review Organization Reports

Report to the Centers for Medicare and Medicaid Services

Quality Monitoring and External Quality Review Organization Reports

Submitted by the Rhode Island Executive Office of Health and Human Services

(EOHHS)

1. The State's Comprehensive 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 for assessing and improving the quality of health care services furnished by managed care organizations.

Rhode Island's Comprehensive Quality Strategy for its Comprehensive Section 1115 Demonstration builds on the State's initial framework for continuous quality improvement, *Strategy for Assessing the Improving the Quality of Managed Care Services Officered under RIte Care.* This seminal framework was one of the first of its kind in the United States, approved by CMS in April 2005, it focused on Rhode Island's first capitated Medicaid managed care program, RIte Care.

Through the Comprehensive Section 1115 Demonstration, Medicaid-funded services on the continuum of care are now organized, financed, and delivered through a single demonstration. [48] This approach provides the infrastructure by which EOHHS can implement a quality strategy that allows for measurement of specific goals and objectives across all Medicaid delivery systems.

EOHHS reviews the Comprehensive Quality Strategy periodically to assess the strategy's effectiveness and update, as needed. The most recent update was made in 2014 to incorporate three major policy initiatives:

- The implementation of Phase One of Rhode Island's program from Medicaid and Medicaid Eligible individuals who are eligible for full Medicaid benefits.
- The enrollment of the Affordable Care Act Medicaid Expansion population (adults between the ages of 19 and 65 years who are at or below the Federal Poverty Level based on household income using the application of a modified adjusted growth income who are not pregnant, not entitled to or enrolled in Medicare, and not eligible for mandatory coverage under the State's Medicaid Plan.
- The December 2013 CMS renewal of the State's Comprehensive Section 1115 Demonstration and associated Special Terms and Conditions.

The Comprehensive Quality Strategy identifies how Rhode Island's quality approach and efforts advance the National Quality Strategy priorities, the fundamental goals of the Comprehensive Section 1115 Demonstration, and the principles of the Rhode Island Medicaid program. The strategy serves as the basis for measuring and making program improvements in terms of timely access to necessary health care services, quality outcomes and cost-effectiveness across the entire Medicaid program.

[48] Excluded from the Comprehensive Section 1115 Demonstration are disproportional share hospital payments; administrative expenses; phased Part D contributions; and payments to local education agencies for services that are furnished only in a school-based setting and for which there is no third-party payer.

2. State Program Oversight Processes-Managed Care

On a monthly basis, Rhode Island Medicaid leads oversight and administration meetings with the State's four Medicaid participating plans: Neighborhood Health Plan of Rhode Island (NHPRI), United Healthcare Community Plan of Rhode Island (UHCP-RI), Tufts Health Plan (which came into the RI Medicaid market recently in March of 2017), and United Healthcare Dental (UHC Dental). These monthly meetings are typically conducted separately with each health plan. Agenda items focus on both standing areas of focus as well as emerging items. Prior to calendar year 2017, health plan oversight meetings were organized into content areas addressed on a cyclic, quarterly basis:

- Operations (January, April, July, October)
- Financial performance (February, May, August, November)
- Quality improvement, compliance, program integrity (March, June, September, December)

Beginning in Quarter 4 of calendar year 2016, Rhode Island Medicaid has transitioned away from the rigid rotation of content areas, moving towards an Active Contract Management model addressing the key areas of focus each month, addressing issues as they arise, and taking deep dives into various topic areas of interest.

Highly qualified individuals who have managed care experience and intimate knowledge of the Rhode Island Medicaid program lead the oversight of managed care (including dental). These professionals serve as the chief liaison between the MCO and Rhode Island Medicaid. Responsibilities include monitoring compliance and contract performance, identifying problem areas, assisting in the development and implementation of corrective actions plans, providing technical assistance to improve quality and cost-effectiveness and ensuring that MCOs are addressing any changes in Federal and State rules and regulations.

Rhode Island Medicaid conducts monthly internal staff meetings to discuss oversight of the MCO contracts and prepare for the monthly oversight meetings with the plans. Rhode Island Medicaid staff identify strategies and develop recommendations for program improvements.

A. STATE-MANDATED QUALITY REPORTING

Rhode Island Medicaid requires its participating MCOs to submit a comprehensive series of reports, which are used for oversight and monitoring. The findings from these reports are analyzed internally and for emerging trends, potential barriers or unmet needs, and quality of care issues. These reports allow Rhode Island Medicaid to identify areas that need to be reviewed with the health plans during the monthly oversight meetings.

Table 1 below is a listing of quality reports that the MCOs are required to submit (and frequency). MCOs are required to submit additional reports, not listed below, for the oversight of operations and finances.

Table 1: Managed Care Quality Reporting		
RIteCare, Rhody Health Partners, Rhody Health Expansion, and CSN populations (NHPRI and UHCP-RI)	Rite Smiles (UHC Dental)	Rhody Health Options (NHPRI)
1. Accountable Entity attributed lives reports (quarterly) 2. Annual compliance plan (annually) 3. Annual quality plan and evaluation (annually) 4. Alternative payment methodology reporting (quarterly) 5. CAHPS® data (annually) 6. Communities of Care (quarterly) 7. Grievances and appeals (quarterly) 8. HEDIS data (annually) 9. Informal complaints (quarterly) 10. Pain Management (quarterly) 11. PCP reporting (quarterly) 12. Pharmacy reports (quarterly) 13. Provider panel report (quarterly) 14. Provider snapshot access survey results (twice annually) 15. Quality Improvement Project and Performance Goal Program activities (quarterly) 16. Secret shopper access survey (twice annually) 17. High utilizer report (quarterly)	1. Annual compliance plan (annually) 2. Annual quality plan and evaluation (annually) 3. Grievances and appeals (quarterly) 4. HEDIS® data (annually) 5. Informal complaints (quarterly) 6. Member satisfaction survey results (annually) 7. Provider panel report (quarterly) 8. Provider satisfaction survey results (annually) 9. Provider snapshot access survey results (twice annually) 10. Quality Improvement Project activities (quarterly) 11. Secret shopper access survey (twice annually) 12. Utilization (quarterly)	1. Not a Candidate report (monthly) 2. 24-hours emergency back-up report (quarterly) 3. Accountable Entity attributed lives report (quarterly) 4. Annual compliance plan (annually) 5. Annual quality plan and evaluation (annually) 6. Care transitions (quarterly) 7. DEA service utilization (monthly) 8. Home care access (bi-weekly) 9. LTSS expenditure (twice per year) 10. LTSS operational reports (quarterly) 11. Nursing Home Transition Program and Money Follows the Person import file (monthly) 12. Nursing home quality report (quarterly) 13. Provider panel report (quarterly) 14. Provider snapshot access survey results (quarterly) 15. Pharmacy generics first (quarterly) 16. Pharmacy Home (quarterly) 17. Special purchases-Personal Choice (quarterly)

B. EXTERNAL QUALITY REVIEW

Federal regulations require an annual External Quality Review (EQR) of Rhode Island's Medicaid managed care program to be conducted by an independent contractor and submitted to the Centers for Medicare and Medicaid Services. Rhode Island Medicaid has been committed to an EQR as an important quality improvement process prior to the promulgation of this Federal regulation. Rhode Island Medicaid contracts with Island Peer Review Organization (IPRO) to conduct this EQR function. IPRO is responsible for the assessment and reporting of the impact of the managed care programs on the accessibility, timeliness and quality of services.

Each year, IPRO produces health plan-specific technical reports and an aggregated EQR report of the mandatory EQR-related activities. Beginning in reporting year 2015, IPRO produced two additional health plan-specific reports for Rhody Health Options, managed long-term services and supports, and RIte Smiles, managed dental benefits for children. These reports provide the health plans and EOHHS with an analysis of key findings of successes and opportunities as well as recommendations for focused activities in the coming year.

In developing the annual EQR reports, IPRO analyzes a rich and diverse set of qualitative and quantitative data, including the following from each of the health plans:

- Geo Access provider network analyses
- CAHPS® member satisfaction survey reports from NCQA-certified CAHPS® auditor
- HEDIS® rates and audit reports from NCQA-certified HEDIS® auditor
- Enrollment data
- NCQA accreditation survey findings
- Performance Goal Program results
- Quality Improvement Project results
- Quality Improvement Program Descriptions
- Care management reports
- Health plan's responses to previous year's technical report recommendations

EOHHS shares the technical and aggregated reports with the Rhode Island Regional and CMS Federal Officers. Additionally, the aggregated report is posted publicly to the EOHHS website. The reports are also shared with the respective health plans. Each health plan is required to provide response to the feedback and recommendations made by the EQRO.

In the 2015 aggregate report, IPRO stated the following conclusion:

"*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 were awards an overall rating of four and half (4.5) out of five (5) as Medicaid Health Plans by the NCQA for 2015."[49]

The most recent aggregate report can be accessed at the following link: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/2015AggregateEQRTechnicalReport.pdf

In March of 2016, IPRO also conducted an optional EQR-related activity for the state to focus on access to primary care, specialty care, behavioral health care, and dental services (as applicable) in the wake of the Affordable Care Act expansion of Medicaid. IPRO conducted Secret Shopper Surveys as a new member (of each health plan) seeking appointments. IPRO identified opportunities for the health plans (including Dental) to update provider directories, educate provider networks on the State's access standards, and conduct more frequent access studies. Rhode Island Medicaid now requires the health plans to conduct access studies via an IPRO established Secret Shopper Survey methodology and monitors results twice annually.

C. PERFORMANCE GOAL PROGRAM

In 1998, Rhode Island Medicaid established a performance-based incentive program for the MCOs. Rhode Island was the 2nd state in the nation to establish a performance-based system that promotes paying for value.

A significant number of the measures in the Performance Goal Program (PGP) are from standardized measurement sets: HEDIS® and CAHPS®. Rhode Island Medicaid uses Quality Compass comparative percentile rankings to establish benchmarks for HEDIS® and CAHPS® measures. Targets for State-based measures are set according to historical performance and state or national goals.

Incentive awards are distributed across domains and measures with varying weights. MCOs earn the full award per measure by meeting the Quality Compass 90th percentile benchmark or state-target. MCOs may earn a partial award per measure by meeting the Quality Compass 75th percentile benchmark.

Results from the annual PGP are presented to the health plans along with the earned financial incentive. Results are published in an annual report "Monitoring Quality and Access" that is posted on the Rhode Island EOHHS website. The most recent report can be accessed at the following link:
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/MonitoringQualityandAccess102716.pdf

Beginning in Q4 2016, EOHHS now engages with the health plans on a quarterly basis to review progress on PGP measures. As outlined above, the health plans must submit a report each quarter with updated data points for each measure, discuss interventions and identify barriers. EOHHS

[49] Annual External Quality Review Technical Report (Aggregate), Reporting Year 2015, IPRO, Inc, October 2016 (p. 9)

then meets with both health plans at the same time to foster the spirit of shared learning, collaboration, reduce duplication of efforts, and improve the State's ability to identify and address system-level interventions that may impact measures.

The 2017 PGP was made available to the MCOs for RIte Care, Rhody Health Partners and CSN lines of business and separately to the Rhody Health Expansion line of business.

Tables 2 and 3 below display the domains, measures, targets and sources of data for PGP 2017.

Table 2: PGP 2017 for RIte Care, Rhody Health Partners and CSN

Table 2: PGP 2017 for RIte Care, Rhody Health Partners and CSN		
Domain and Measures	**Target**	**Source**
I. UTILIZATION		
Emergency room utilization rate per 1000 (baseline)	Baseline	Encounter Data
Plan all-cause readmission (baseline for all populations RIteCare, CSN, RHP and RHE)	Baseline	HEDIS®
Behavioral health readmission	Baseline	Encounter Data
Well-child visits in 1st 15 mos of life	QC 90th Percentile	HEDIS®
Well-child visits in 3rd-6th yrs of life	QC 90th Percentile	HEDIS®
Adolescent well-care visit	QC 90th Percentile	HEDIS®
Frequency of ongoing prenatal care	QC 90th Percentile	HEDIS®
II. ACCESS TO CARE		
Child and Adolescent Access to Primary Care Practitioner	QC 90th Percentile	HEDIS®
Adult members had an ambulatory or preventive care visit	QC 90th Percentile	HEDIS®
Timeliness of prenatal care	QC 90th Percentile	HEDIS®
Timeliness of postpartum care	QC 90th Percentile	HEDIS®
Initiation and Engagement of Alcohol and Other Drug Dependence	QC 90th Percentile	HEDIS®
Members (>18 years old) were satisfied with access to specialist	QC 90th Percentile	CAHPS®
III. PREVENTION & SCREENING		
Lead Screening	QC 90th Percentile	HEDIS®
Childhood immunization status	QC 90th Percentile	HEDIS®
Immunizations for Adolescents	QC 90th Percentile	HEDIS®
Wgt. Assessment & Counseling	QC 90th Percentile	HEDIS®
Developmental Screening in the first 3 year of life	State-specified	Reported by health plan in PGP Template
Adult BMI Assessment	QC 90th Percentile	HEDIS®
Members (>18 years old) rec'd advice on smoking cessation	QC 90th Percentile	CAHPS®
Flu Vaccination (>18 years old)	QC 90th Percentile	CAHPS®
Breast Cancer Screening	QC 90th Percentile	HEDIS®
IV. WOMEN'S HEALTH		
Women 21-64 rec'd cervical cancer screening	QC 90th Percentile	HEDIS®

Table 2: PGP 2017 for RIte Care, Rhody Health Partners and CSN		
Domain and Measures	**Target**	**Source**
Sexually active women 16-24 rec'd Chlamydia screen	QC 90th Percentile	HEDIS®
V. CHRONIC CARE MANAGEMENT		
Comprehensive Diabetes Care	QC 90th Percentile	HEDIS®
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	QC 90th Percentile	HEDIS®
Medication Management for Asthma	QC 90th Percentile	HEDIS®
Controlling HBP	QC 90th Percentile	HEDIS®
Adults in care with HIV with <200 viral load	State-specified	Reported by health plan in PGP Template
VI. BEHAVIORAL HEALTH		
Follow-Up After Hospitalization for Mental Illness	QC 90th Percentile	HEDIS®
Antidepressant Medication Management	QC 90th Percentile	HEDIS®
Follow-up for children prescribed ADHD-Initiation	QC 90th Percentile	HEDIS®
Follow-up for children prescribed ADHD-Continuation and Maintenance	QC 90th Percentile	HEDIS®
Adherence to Antipsychotic Medications for individuals with Schizophrenia	QC 90th Percentile	HEDIS®
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (baseline)	QC 90th Percentile	HEDIS®
VII. COMPLIANCE		
Timely and accurate submission of encounter data	State-specified	Health plan reporting
VIII. Expanded models of care delivery and payment		
Increase the amount of payments made in alternative payment models (baseline for all populations RIteCare, CSN, RHP and RHE)	State-specified	Health plan reporting

Table 3: PGP 2017 for Rhody Health Expansion

Table 3: PGP 2017 for Rhody Health Expansion		
Domain and Measures	**Target**	**Source**
I. UTILIZATION		
Emergency room utilization rate per 1000 (baseline)	Baseline	Encounter Data
Behavioral health readmission	Baseline	Encounter Data
Frequency of ongoing prenatal care	QC 90th Percentile	HEDIS®
II. ACCESS TO CARE		
Adult members had an ambulatory or preventive care visit	QC 90th Percentile	HEDIS®
Timeliness of prenatal care	QC 90th Percentile	HEDIS®
Timeliness of postpartum care	QC 90th Percentile	HEDIS®
Initiation and Engagement of Alcohol and Other Drug Dependence	QC 90th Percentile	HEDIS®
Members (>18 years old) were satisfied with access to specialist	QC 90th Percentile	CAHPS®
III. PREVENTION & SCREENING		
Adult BMI Assessment	QC 90th Percentile	HEDIS®
Members (>18 years old) rec'd advice on smoking cessation	QC 90th Percentile	CAHPS®
Flu Vaccination (>18 years old)	QC 90th Percentile	CAHPS®
Breast Cancer Screening	QC 90th Percentile	HEDIS®
IV. WOMEN'S HEALTH		
Women 21-64 rec'd cervical cancer screening	QC 90th Percentile	HEDIS®
Sexually active women 16-24 rec'd Chlamydia screen	QC 90th Percentile	HEDIS®
V. CHRONIC CARE MANAGEMENT		
Comprehensive Diabetes Care	QC 90th Percentile	HEDIS®
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	QC 90th Percentile	HEDIS®
Medication Management for Asthma	QC 90th Percentile	HEDIS®
Controlling HBP	QC 90th Percentile	HEDIS®
Adults with HIV with <200 viral load	State-specified	Reported by health plan in PGP Template
VI. BEHAVIORAL HEALTH		
Follow-Up After Hospitalization for Mental Illness	QC 90th Percentile	HEDIS®
Antidepressant Medication Management	QC 90th Percentile	HEDIS®
Adherence to Antipsychotic Medications for individuals with Schizophrenia	QC 90th Percentile	HEDIS®
VII. COMPLIANCE		
Timely and accurate submission of encounter data	State-specified	Health plan reporting

D. STATE-MANDATED QUALITY IMPROVEMENT PROJECTS

Federal managed care regulations require MCOs to conduct annual Performance Improvement Projects (called "Quality Improvement Projects" in Rhode Island Medicaid). Quality Improvement Projects are required in the core Medicaid Managed Care Services contract; in the Rhody Health Options contracts, and in the RIte Smiles contract.

Rhode Island Medicaid requires that each health plan organizes 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 form provides a robust set of standards and guidance for summarizing quality improvement activities.

Beginning in Q4 2016, EOHHS now engages with the health plans on a quarterly basis to review progress on Quality Improvement Projects, similarly to the State's engagement on Performance Goal Program measures. As outlined in the reporting requirements above, the health plans must submit a report each quarter with updated data points for each measure, discuss interventions and identify barriers. EOHHS then meets with both health plans at the same time to foster the spirit of shared learning and collaboration, reduce duplication of efforts, and to improve the State's ability to identify and address system-level interventions that may impact measures. Findings from the Quality Improvement Projects are also presented to the State's EQRO for validation purposes each year.

Rhode Island Medicaid sets forth the areas of focus for the health plan's annual Quality Improvement Projects based on our synthesis of qualitative and quantitative measures, HEDIS® and CAHPS® results, findings from the annual Performance Goal Program, and recommendations from the EQRO.

For calendar year 2017 the following Quality Improvement Projects are in process for each health plan:

<table>
<tr><th colspan="3">Table 4: 2017 Quality Improvement Project Topics</th></tr>
<tr><th>RIteCare, Rhody Health Partners, Rhody Health Expansion, and CSN populations (NHPRI and UHCP-RI)</th><th>Rite Smiles (UHC Dental)</th><th>Rhody Health Options (NHPRI)</th></tr>
<tr><td>Developmental screening in the first three years of life</td><td>Preventive [oral] health services</td><td rowspan="4">Transitions from the nursing home to the community who are eligible for the Rhode to Home Program</td></tr>
<tr><td>Antidepressant medication management</td><td rowspan="3">Dental sealants on first or second molar</td></tr>
<tr><td>Initiation and engagement of alcohol and other drug dependence</td></tr>
<tr><td>A measure of the health plans' choosing related to social determinants of health (measure definition and specifications to be approved by Rhode Island Medicaid). Measure must be related to housing, education, literacy, food security, employment, transportation, criminal justice involvement, or intimate partner violence.</td></tr>
</table>

E. ACCREDITATION BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Rhode Island has required its Medicaid participating health plans to be accredited by the National Committee for Quality Assurance (NCQA) since the inception of our State's managed care program in 1994. NCQA is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. NCQA is the most widely-recognized accreditation program in the US, accrediting health plans in every state as well as the District of Columbia and Puerto Rico.

NCQA issues an accreditation status based on the health plan's performance against the rigorous standards and audited HEDIS® and CAHPS® results. The standards evaluate the health plan's quality management and improvement, network management, utilization management, credentialing and re-credentialing, member's rights and responsibilities, member connections, and Medicaid benefits and services. The highest accreditation status issued is "Excellent," followed by "Commendable," "Accredited," "Provisional," "Interim," then "Denied."

The Rhode Island core Medicaid Managed Care Services contract maintains a performance "floor" such that a "Provisional" accreditation status requires a corrective action plan within 30 days and may result in contract termination. Additionally, any denial of accreditation by NQCA shall be considered cause for termination of the State's contract with the MCO. Health plans are required to share with Rhode Island Medicaid any communications pertaining to the MCO's accreditation by NCQA as well as actual HEDIS® and CAHPS® data, transmittals and reports.

Currently, both Neighborhood Health Plan of Rhode Island and United Healthcare Community Plan of Rhode Island are accredited with "Excellent" status affirming their programs for services and clinical quality meet or exceed rigorous requirements for consumer protection and quality improvement. HEDIS® and CAHPS® results are in the highest range of national performance.[50] Images 1 and 2 below represent each MCO's current star results across each of the five dimensions that comprise the overall "Excellent" accreditation status.

[50] National Committee for Quality Assurance "Accreditation Levels" http://www.ncqa.org/Programs/Accreditation/health-plan-hp/Accreditation-Levels

Image 1: Neighborhood Health Plan of Rhode Island NCQA Star Results

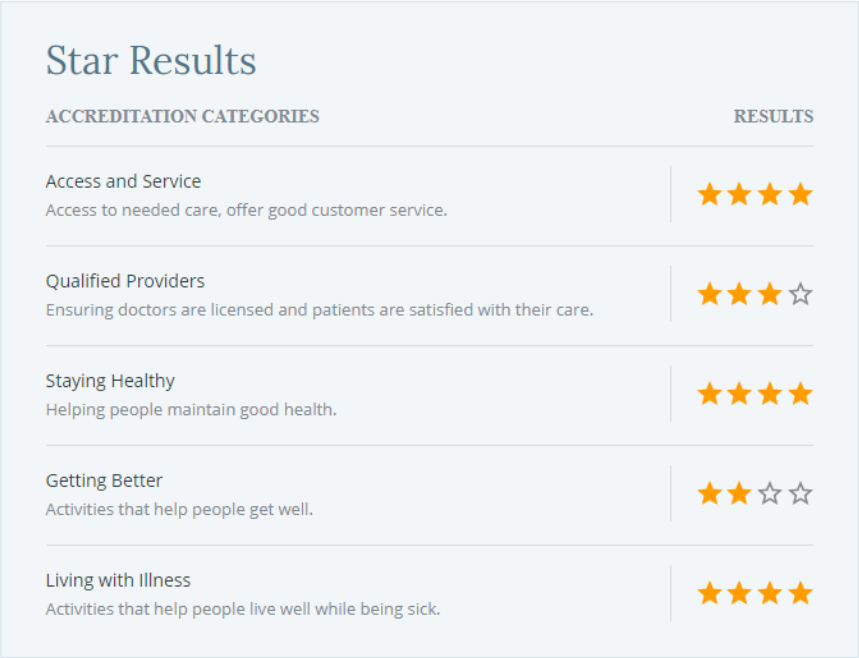
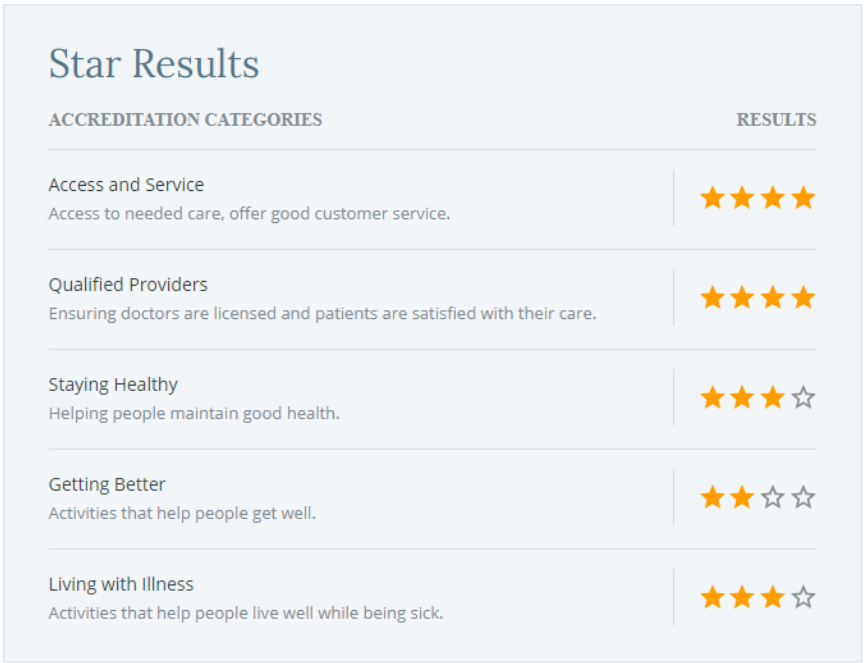


Image 2: United Healthcare Community Plan of Rhode Island NCQA Star Results



F. HEDIS® QUALITY MEASURES

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. HEDIS® originated in the late 1980's and was entrusted to NCQA in the 1990's. The HEDIS® measure set addresses a broad range of important health issues and evolves year over year to represent the information purchasers and consumers value. HEDIS® measures require strict measure specifications and must be audited by certified auditors, allowing comparison of performance across health plans.

HEDIS® performance is a key component of NCQA Accreditation, thus the MCOs report on over 30 measures each year to NCQA and to Rhode Island Medicaid. Measures are analyzed by Rhode Island's EQRO each year and trended over a three-year period. As previously discussed, these analyses inform which measures will be used for the Performance Goal Program and State-mandated Quality Improvement Projects and helps determine other areas of focus in the State's oversight of the MCOs.

G. CAHPS® MEMBER SATISFACTION SURVEY

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a survey of health plan enrollees' experience with health care. Surveys are designed to assess aspects of quality that the enrollee can best assess, such as communication skills of providers and ease of access to health care services.

Health plans report survey results as part of HEDIS® data collection and component of NCQA Accreditation. Therefore, survey results are shared with NCQA and Rhode Island Medicaid each year. Results are also analyzed by Rhode Island's EQRO. As previously discussed, these analyses inform which measures will be used for the Performance Goal Program and State-mandated Quality Improvement Projects and helps determine other areas of focus in the State's oversight of the MCOs.

3. State Program Oversight Processes-Home and Community-Based Services

Rhode Island Medicaid is responsible for ensuring that the following six assurances that pertain to 1915(c) home and community-based waiver services (HCBS) are met:

1) Level of Care Determination: Person enrolled has needs consistent with the designated level of care evaluation
2) Service Plan: Participants have a service plan that is appropriate to their need and receive the services and supports outlined in their plan
3) Qualified Providers: Providers are qualified to deliver services and supports
4) Health and Welfare: Beneficiaries' health and welfare are safeguarded and monitored
5) Financial Accountability: Claims for waiver services are paid per State payment methodologies
6) Administrative Authority: Medicaid agency is involved in the oversight of the waiver and overall responsibility of the program.

The following is a snapshot of metrics that are currently submitted to CMS on a quarterly basis:

- Level of Care Determinations stratified by the following categories (Highest, High, Preventive)
- Percentage of Nursing Home Transition Referrals and Placements
- Percentage of Medicaid beneficiaries in Institutional and HCBS LTC settings, inclusive of cost and utilization of service units
- Percent distribution of expenditures for Long-Term Care Institutional and HCBS by population, including elders 65 years and older, adults with disabilities, and children with special health care needs
- Number of Medicaid beneficiaries on a waiting list for any Long-Term Care service
- Percentage of individuals in a non-Medicaid funded Long-Term Care co-pay program by type, unit of service, and expenditures

The current methods utilized by each HCBS program for ongoing monitoring and performance measurement include, but are not limited to the following elements:

- Case Records Reviews
- Provider monitoring, including Background Criminal Investigation
- Fiscal and eligibility review, including utilization reviews
- Functional Status 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, monitoring outcomes, and updates are presented at the monthly (Rhode Island Medicaid) internal staff meetings, allowing collaboration and alignment of quality oversight across all Medicaid programs.

Rhode Island Medicaid is currently in the process of revamping its quality and oversight of HCBS to ensure alignment and compliance with the recent modification to the §1915(c) HCBS waivers and recently promulgated rules regarding person-centering planning and HCBS settings. In 2015, Medicaid engaged in an annual audit of all HCBS programs, both FFS and managed care. As part of this process, a random sample of records from each program or of combined populations was evaluated to assess and identify baseline performance of Home and Community-Based Services for each assurance across all HCBS programs.

4. State Program Oversight Processes-Program All-Inclusive for the Elderly

Federal regulations outline quality requirements for Program All-Inclusive for the Elderly (PACE). These requirements are established under the Social Security Act and are requisite elements in the PACE program agreement between the PACE Organization (PACE Organization of Rhode Island, Inc), CMS and the State's Administering Agency (Rhode Island Medicaid). Collaboration amongst these three entities is expected on the development and implementation of quality of life outcomes.

The following "Level One" reports are provided to both Rhode Island Medicaid and CMS by PACE Organization of Rhode Island, Inc with aggregate and individual-level data:

- Routine immunizations
- Grievances and appeals
- Enrollments
- Disenrollments
- Prospective enrollees
- Readmissions
- Emergency (unscheduled) care
- Unusual incidents
- Deaths

The following "Level Two" reports are provided to both Rhode Island Medicaid and CMS by PACE Organization of Rhode Island, Inc within 48 hours of occurrence:

- Death
- Infectious disease outbreaks
- Falls
- Pressure ulcers

Upon reporting a Level Two occurrence, PACE Organization of Rhode Island, Inc 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 conduct a root-cause analysis of the incident, identifying any "system" failures and improvement opportunities. PACE Organization of Rhode Island, Inc must also prepare a case presentation for a telephone discussion with CMS and Rhode Island Medicaid.

PACE Organization of Rhode Island, Inc must develop a Quality Assessment and Performance Improvement Plan. This plan 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 including, but not limited to:
  - Utilization of services (hospitalization and emergency department 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 area including grievances and appeals
  - Development and implementation of plans of action to improve or maintain quality of care

Rhode Island Medicaid holds quarterly oversight meetings with PACE Organization of Rhode Island, Inc to discuss operational, financial, quality and compliance issues. In advance of these

meetings, PACE Organization of Rhode Island submits to Rhode Island Medicaid the Quality Assessment and Performance Improvement Plan, results from quarterly measurements, and patient satisfaction survey outcomes. PACE Organization of Rhode Island, Inc holds monthly quality meetings to review progress on these goals. Results are submitted to CMS every two years as part of the CMS and Rhode Island Medicaid site visit. The measures identified in this process are set by ongoing needs assessments and CMS recommendations per the site visit reviews.

Additionally, key findings and updates are presented at the monthly (Rhode Island Medicaid) internal staff meetings, allowing collaboration and alignment of quality oversight across all Medicaid programs.

5. CMS Form 416 Reporting

The State's CMS 416: Annual EPSDT Participation Report is produced annually and focuses on Rhode Island Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The CMS 416 includes but is not limited to:

- Screening Ratio
- Participant Ratio
- Total Eligibles referred for corrective treatment
- 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 Eligibles receiving oral health services by a non-dentist provider
- Total number of screening blood lead tests

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

Upon submission of this report to CMS, findings are shared with the managed dental benefit plan, United Healthcare Dental, and with the managed medical plans. Results are also incorporated into the EQR report for dental. Results from this report and recommendations from the EQR drive the topic selection for Quality Improvement Projects.

6. CMS Core Quality Measure Reporting

Rhode Island Medicaid participates in voluntary quality measure reporting through CMS each year. In the most recent reporting year, Rhode Island Medicaid reported on the Child Core Set, Adult Core Set and Health Home Core Set (for the Cedar Health Home for Children and Youth with Special Health Care Needs).

In 2014, Rhode Island Medicaid was ranked number one in child quality for reporting the highest number of measures and for having a high performance on reported measures. CMS no longer provides an overall ranking. However, they do publish an annual report that compares states and Rhode Island continues to outperform other states across most reported measures. Additionally, Rhode Island Medicaid uses the Core Measure Sets to inform the measures used in its Performance Goal Program, Quality Improvement Projects, and measures used to assess the performance outcomes of various Medicaid programs.

A. CHILD CORE:

In 2016, Rhode Island Medicaid reported on 19 out of 26 measures. This includes one additional measure over the previous year's report: *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*. The data for the Child Core reports is calculated the health plans' HEDIS® and CAHPS® data. Additionally, Rhode Island Medicaid incorporated non-HEDIS® and non-CAHPS® Child Core measures into the health plans required Quality Improvement Projects to collect and report this data.

- Several measures increased from 2015 to 2016: *Developmental Screening in the First Three Years of Life*, *Child and Adolescent Access to Primary Care (12-19 year olds)*, *Timeliness of Prenatal Care*, and *Medication Management for People with Asthma*.
- Fourteen measures remained the same or had a slight decrease in rates reported from 2015 to 2016. These measures had overall high performance and rank in the 75th or 90th percentile according to Quality Compass 2015 Rankings.
- One measure showed a decrease in performance and does not meet the 75th or 90th percentile rankings: *Children and Adolescent Access to Primary Care for 12-24 month olds*. The health plans attribute this decline to issues with identifying and de-duplicating newborns.

B. ADULT CORE:

In 2016, Rhode Island Medicaid reported 18 out of 30 measures. This includes one additional measure over the previous year's report: *HIV Viral Load Suppression.* Another key difference in this year's report, is that the data was derived solely from the health plans through HEDIS®, CAHPS® and Quality Improvement Projects. In previous year under the Adult Medicaid Quality Grant, Rhode Island Medicaid calculated measures to combine health-plan reported data with the data for the Medicaid Fee-For-Service population. However, a sufficient (and growing) portion of the population now receive their care through a managed care organization and the reports from the health plans sufficiently represent our total population.

- Several measures increased from 2015 to 2016: *Adult Body Mass Index Assessment, Postpartum Care Rate, and Controlling High Blood Pressure.*
- Measures that remained the same, but have overall high performance include *Comprehensive Diabetes Care* measures and *Follow-up After Hospitalizations for*

Mental Illness. These measures have overall high performance and rank in the 75th or 90th percentile according to Quality Compass 2015 Rankings.

- Three measures decreased or did not meet the 75th or 90th percentile rankings: *Chlamydia Screening in Women Ages 21-24*, *Adherence to Antipsychotics for Individuals with Schizophrenia*, and *Antidepressant Medication Management.* These measures will remain a focus in future Performance Goal Program, Quality Improvement Projects and/or specific program performance outcomes.

C. HEALTH HOME CORE

In 2017, Rhode Island Medicaid reported on the Health Home Core Set for the Cedar Health Homes for Children and Youth with Special Health Care Needs for Federal Fiscal Years 2014, 2015 and 2016. Rhode Island Medicaid reported on 7 out of 11 measures as measures that are relevant to the Cedar population and feasible to calculate.

Performance on the reported measures is relatively low (compared to performance of similar measures in other Rhode Island Medicaid programs). However, this can be attributed to small population size (more susceptible to frequent changes due to chance); missing behavioral health claims from encounter data; and a lack of systematic tracking of data in the Cedar medical records. EOHHS is actively working on addressing the improvement of encounter data. Beginning in calendar year 2016, EOHHS implemented a new system of tracking Cedar medical record data. Rhode Island Medicaid expects to see greater improvements on these measures in future reporting years.

In 2017, the Rhode Island agency for Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) reported on the Health Home Core Set for two additional health home programs for Federal Fiscal Years 2014, 2015 and 2016. As BHDDH is the licensing agency for the facilities operating these health home programs, they currently have the best source of historical information to calculate these Health Home Core Measures. However, both the Integrated Health Homes and Opioid Treatment Health Home services have been moved into managed care. Going forward, Rhode Island Medicaid will partner with BHDDH, the health plans, and the providers to calculate these measures. The Health Home Core Set measures will inform the set of performance outcomes measures that are shared with the providers on a quarterly basis for the purpose of quality improvement and best practice sharing.

Attachment F: Evaluation Design for Future Demonstration (2019-2023)

DRAFT EVALUATION STRATEGY FOR RHODE ISLAND's
SECTION 1115 DEMONSTRATION
PROJECT NO. 11-W-00242/1

January 1, 2019 – December 31, 2023

Section 1. Introduction

Since the approval of the initial 1115 Demonstration Waiver in 2009, EOHHS has drawn upon lessons learned from significant events to continually reform and refine the Medicaid program. The newly requested changes to the Demonstration for the second five-year extension will afford EOHHS the authorities and flexibilities that are essential to successfully transforming Rhode Island's Medicaid program. As discussed in Section 1 of the Demonstration Extension Request, the guiding principles and strategic goals have been refined to reflect the focused efforts to transform the Medicaid program.

This document describes the methods, measures, and data that will be utilized to evaluate the three (3) hypotheses associated with the guiding principles of the Demonstration:

1. Providing care through an AE will increase coordination of services among medical, behavioral, and specialty providers resulting in better outcomes of Medicaid beneficiaries, while decreasing total cost of care.
2. By coordinating the majority of beneficiaries' care, Primary Care Physician (PCP) and other preventative visits will increase and ambulatory sensitive emergency department visits and inpatient stays will decrease.
3. Delivering appropriate care in the community will rebalance services and costs, resulting in an increase in HCBS and a decrease in custodial care placements.

Section 2: Demonstration Evaluation Design

2.1 SCOPE

EOHHS is required to evaluate the Demonstration by integrating the outcomes from each evaluation component into one programmatic summary as outlined in
STC 128. Detail is provided below related to the methods and measures EOHHS will implement to evaluate the demonstration according to CMS specifications.

2.2 METHODS

Quantitative analyses will be conducted using secondary data, including, but not limited to, Medicaid eligibility and enrollment data from MMIS, Medicare and Medicaid claims, managed care encounter data, as well as elements from the Minimum Data Set (MDS), Level of Care Determination, and Home and Community Based Services (HCBS) Authorization File. The observation period of interest will include the years 2017-2023, with the time origin representing two years prior to the renewal of the Demonstration. Both descriptive and multivariate modeling will provide estimates for process implementation, trends in costs associated with the Demonstration and outcomes over time. Additional primary datasets will be developed as various components of this Evaluation Strategy are implemented. If sampling frames are required, care will be taken to assure that there is a sample size of adequate power to support any conclusions. All datasets will be developed with credible edits to assure their validity and completeness.

The evaluation will assess differences in both process and outcome variables, including cost and utilization patterns, among members using various delivery systems (MCO or PCCM) and coverage types (Medicaid only or MMP). Variables that have not been previously defined will be operationalized within the respective hypotheses to follow. Appropriate statistical analyses will be selected for each hypothesis. For dichotomous comparisons, chi-square and odds ratios with 95% confidence intervals will be utilized. Interval comparisons will be assessed using t-tests. Additionally, multivariate models to address the impact of the Demonstration on outcomes of interest, adjusted for all known covariates, will be employed.

2.3 MEASURE CONSTRUCTION

PRINCIPLE 1: PAY FOR VALUE, NOT FOR VOLUME.

Hypothesis: Providing care through an AE will increase coordination of services among medical, behavioral, and specialty providers resulting in better outcomes of Medicaid beneficiaries, while decreasing total cost of care.

Measure 1: Total expenditures for all attributed patients to the AE (as defined and outlined in the *OOH Total Cost of Care (TCOC) Guidance* Document).

Denominator: Number of people enrolled in an AE population as of December 31 of measurement year.

Numerator: Number of people in each budget population/sub-population who had at least one outpatient visit (i.e., CPT code 99201-99215 or 99381-99397) with their PCP during measurement year.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Rationale: The AE model's primary objective is to transition to an integrated care model in which provider networks can better address care for the whole person and avoid duplications as well as improve timing and delivery to avoid high-cost settings. Total cost of care should be reflected as the total expenditures for all attributed patients to the AE (as defined and outlined in the *Total Cost of Care (TCOC) Guidance* Document).

Measure 2: Percent of Care Delivered in the Attributed AE.

Denominator: Total visits in each subset (outpatient visits by claim type, BH visits based on primary diagnosis, annual well visit based on procedure code and provider taxonomy, specialist visits based on visit code and provider taxonomy).

Numerator: Total visits in each subset at each of the attributed AE site or with the attributed primary care physician (PCP).

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Rationale: See Measure 1 rationale.

Measure 3: Percent of recipients in an attributed AE utilizing the emergency department annually (Annual ED visit/1,000)

Denominator: Number of AE enrollees as of December 31 of measurement year: Unduplicated count of people and member months.

Numerator: Number of ED visits, among AE enrollees, in the measurement year.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Rationale: See Measure 1 rationale.

Measure 4: Percent of recipients AE enrollees with an inpatient admission (IP) annually (Annual IP admits/1,000)

Denominator: Number of AE enrollees as of December 31 of measurement year: Unduplicated count of people and member months.

Numerator: Number of IP admissions, among AE enrollees, in the measurement year.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Rationale: See Measure 1 rationale.

Measure 5: Percent of AE enrollees with an Annual Well Visit (AE Member Visit/1, 000)

Denominator: Number of total continuously enrolled (9 out of 12 months) AE attributed members.

Numerator: Number of continuously enrolled (9 out of 12 months) AE members who have had at least 1 well-visit within the span of the year.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Rationale: See Measure 1 rationale.

Measure 6: Percent of AE enrollees that churn overall and churn by AE.

Denominator: Number of total continuously enrolled (9 out of 12 months) AE

attributed members).

Numerator:
1.) Number of AE enrollees who are no longer attributed to their original AE,
2.) Number of AE enrollees who move from their original AE to a different AE attribution.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Rationale: See Measure 1 rationale.

PRINCIPLE 2: COORDINATE PHYSICAL, BEHAVIORAL, AND LONG-TERM HEALTH CARE.

Hypothesis: By coordinating the majority of beneficiaries' care, Primary Care Physician (PCP) and other preventative visits will increase and ambulatory sensitive emergency department visits and inpatient stays will decrease.

Measure 1: Percent of recipients who have at least one outpatient visit with their primary care provider annually.

Denominator: Number of people enrolled in each budget population/sub-population as of December 31 of measurement year.

Numerator: Number of people in each budget population/sub-population who had at least one outpatient visit (i.e., CPT code 99201-99215 or 99381-99397) with their PCP during measurement year.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Rationale: Annual PCP visits are preventative to assure patients conditions are controlled over time. Further, patients with an established PCP relationship are less likely to seek health care in external venues (i.e., ED's) that are costlier because they have an overall care management plan that is an essential component of all care management systems.

Measure 2: Percent of recipients assigned to an Accountable Entity (AE) quarterly.

Denominator: Number of people enrolled in each budget population/sub-population as of December 31 of measurement year.

Numerator: Number of people in each budget population/sub-population assigned to an AE site.

Data Sources: MMIS Eligibility and Enrollment Files.

Rationale: This measure is designed to assure that all Medicaid recipients in RI are associated with one of several established care management systems. Each of these systems will be held accountable for the services provided to populations assigned to their care. EOHHS will also assess performance on a variety of parameters to identify model delivery systems for provision of care across the continuum.

PRINCIPLE 3: REBALANCE THE DELIVERY SYSTEM AWAY FROM HIGH-COST SETTINGS.

Hypothesis: Delivering appropriate care in the least restrictive setting in the community, will rebalance services and costs, resulting in an increase in HCBS and a decrease in custodial care placements.

Measure 1: Percent of recipients who receive HCBS services in Parent and Youth Peer Support, Developmentally Disabled population, and Coordinated Specialty Care populations.

Denominator: Medicaid population who qualify for HCBS during the measurement year.

Numerator: Total Medicaid recipients receiving HCBS by population.

Data Sources: RI EOHHS Data Warehouse. MMIS Eligibility/Enrollment Files as well as Claims-based MC837 and FFS837 claims.

Rationale: Reasonable re-balancing efforts need to monitor HCBS and transitions from community settings to inpatient settings (i.e. nursing home, group home, psychiatric residential facilities) and assure that patients are held harmless in the process. The effectiveness of these services should bend the cost curve in a favorable direction.

Measure 2: Percent of recipients who score in each level of care at risk for custodial placement.

Denominator: Medicaid patients with a paid claim from the custodial placement during the measurement year.

Numerator: Medicaid patients at each level of care during the measurement year.

Data Sources: RI EOHHS Data Warehouse.

Rationale: Attempts to re-balance LTSS are based on the assumption that there are people in custodial placement who could be more effectively treated in the community at a lower cost. These level of care assessments identify the populations likely to have better outcomes in the community setting.

Measure 3: Percent of recipients utilizing the emergency department annually (Annual ED visit/1,000)

Denominator: Number of people enrolled in each budget population/sub-population as of December 31 of measurement year: Unduplicated count of people and member months.

Numerator: Number of ED visits in the measurement. Broken out by Medical and Behavioral Health Diagnoses.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Rationale: Rebalancing LTSS ensures that recipients receive appropriate services in the least restrictive and most appropriate setting and are therefore less likely to require emergency department and inpatient services.

Measure 4: Percent of recipients with an inpatient admission (IP) annually (Annual IP admits/1,000)

Denominator: Number of people enrolled in each budget population/sub-population as of December 31 of measurement year (Unduplicated count of people and member months).

Numerator: Number of IP admissions in the measurement broken out by Medical and Behavioral Health Diagnoses.

Data Sources: MMIS Eligibility/Enrollment Files linked to claims-based data files (MC837 and ffs837) claims.

Rationale: See Measure 3 rationale.