Executive Office of Health & Human Services | 3 West Road – Virks Building | Cranston, RI 02920

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

5/31/2018 PUBLIC NOTICE OF PROPOSED RHODE ISLAND COMPREHENSIVE 1115 DEMONSTRATION WAIVER EXTENSION REQUEST

In accordance Rhode Island General Laws Chapter 42-35, notice is hereby given that the Rhode Island (RI) Executive Office of Health and Human Services (EOHHS) proposes to submit to the Centers for Medicare and Medicaid Services (CMS) its request to extend the Rhode Island Comprehensive 1115 Demonstration Waiver (11-W-00242/1) ("Demonstration") through December 31, 2023, (as the current Demonstration expires on December 31, 2018) with additional waiver and expenditure authorities that will allow EOHHS to continue to make improvements to the Medicaid program.

EOHHS previously issued public notice on the March 23, 2018 and is reissuing notice with additional information in the public notice document as required by 42 CFR 431.408. Please note that there have been no substantive changes made to the Draft 1115 Waiver Extension Request document that was posted on the EOHHS website on March 23, 2018.

Public Comment Process

The proposed extension is accessible on the EOHHS website (http://www.eohhs.ri.gov/ReferenceCenter/MedicaidStatePlanand1115Waiver/WaiverExtension.aspx) or available in hard copy upon request (401-462-6348 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by **June 30, 2018** to Melody Lawrence, Executive Office of Health and Human Services, 3 West Rd, Cranston, RI, 02920, or melody.lawrence@ohhs.ri.gov.

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Public Hearings Held

In April 2018, EOHHS held three (3) public hearings in three geographically distinct areas of the state as detailed in the chart below. Since there are no substantive changes to the Draft 1115 Waiver Extension Request, EOHHS does not intend to hold any additional public hearings during this additional 30-day public comment period.

Public Hearing #1	Public Hearing #2	Public Hearing #3
April 2, 2018 3:30-4:30pm Westerly Public Library & Wilcox Park 44 Broad Street Westerly, RI 02891	April 3, 2018 10:00-11:00am Woonsocket Public Library 303 Clinton Street Woonsocket, RI 02895	April 10, 2018 3:30-4:30pm 2nd Fl Conf Rm 301 Metro Centre Blvd Warwick, RI 02886

During the public hearings, attendees had the opportunity to verbally ask questions or provide comments, and EOHHS staff responded verbally. In May 2018, EOHHS posted a summary of comments document on the EOHHS website, describing the questions or issues received, EOHHS' responses, and what changes were made to the extension request.

Background and Program Description

Section 1115 Demonstration Waivers allow states to waive certain sections of federal Medicaid requirements, affording flexibilities to design and improve their programs in innovative ways that still support the objectives of the Medicaid/CHIP program. EOHHS operates its entire Medicaid program under the Rhode Island Comprehensive 1115 Waiver Demonstration ("Demonstration"), except for: 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. The Demonstration provides EOHHS federal authority to cover individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

The current Demonstration expires on December 31, 2018. EOHHS intends to request a five-year extension of the Demonstration, with additional waiver and expenditure authorities to allow EOHHS to continue improving the Medicaid program.

Principles, Goals, and Objectives of the 1115 Waiver Extension

Over the last three years, Rhode Island has undertaken a comprehensive strategic process to ensure the Medicaid program effectively serves its beneficiaries while being a good steward of the state and federal dollars used to finance it. In 2015, 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 to reduce 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 healthcare in Rhode Island. The report established the principles and goals outlined in Table 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: 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 healthcare	• **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). Because of the HSTP and other healthcare 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).

Waiver and Expenditure Authorities Being Sought

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

Rhode Island seeks the authorities necessary to ensure that, in pursuing these ends, the Rhode Island Medicaid program is sustainable in the future. EOHHS requests all current authorities – including all State Plan services included in the Demonstration as well as Demonstration only benefits – to remain in force. EOHHS also seeks additional authorities to improve the way Medicaid can deliver services. This extension request constitutes EOHHS' request for the authority, or flexibility, to receive federal matching funds. Securing state appropriations needed to implement these waivers/services is a separate process that must go through the usual budget processes.

Current Waivers

EOHHS requests a renewal of all current waivers of Title XIX requirements listed below. A list of new waivers being requested can be found further in Table 2.

- **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.

- **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.

- **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.

- **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.

- **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.

- **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.

- **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.

- **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 in the current Demonstration, which are outlined in this Section.

Expenditures Related to Eligibility Expansion

- 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.

- 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.

- 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.

- 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.

- Parents pursuing behavioral health treatment with children temporarily in state custody with income up to 200 percent of the FPL.

- Children with special health care needs (as an eligibility factor) who are 21 and under who would otherwise be placed in voluntary state custody below 300 percent SSI.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

Note that some Title XIX requirements do not apply to specific demonstration populations as follows:

- 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, Section 1902(a)(10)(B), Amount, Duration, and Scope does not apply, thereby enabling Rhode Island to provide a benefit package consisting only of approved family planning and family planning-related services.

- For some select populations, Section 1902(a)(10)(B), Amount, Duration, and Scope does not apply, thereby enabling Rhode Island to provide a limited benefit package.

<u>CHIP Expenditure Authority</u>

- 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.

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

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

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

- 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.

Expenditures Related to Service Expansion

- Window replacement for homes which are the primary residence of eligible children who are lead poisoned.

- 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.

- Cost of designated programs that provide or support the provision of health services that are otherwise state-funded, including:

    - The Wavemaker Fellowship Program, Tuberculosis Clinic, Rhode Island Child Audiology Center, Center for Acute Infectious Disease and Epidemiology, Consumer Assistance Program, and Health Workforce Development (including the state's three public institutes of higher education).

    - 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.

    - 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.

    - 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.

    - 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.

- **Demonstration Benefits.** These include the following:

- Expenditures for benefits provided only to beneficiaries enrolled in Managed Care, which are not otherwise available in the Medicaid State Plan.
- 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.
- Expenditures for core and preventive services for Medicaid eligible at risk youth.

- Individuals who would otherwise lose Medicaid eligibility pending coverage in a QHP.

- Healthy behaviors incentives.

- A limited set of LTC benefits for individuals who self-attest to financial eligibility factors.

- Delivery of a recovery-oriented environment and care plan dedicated to connecting individuals with a substance use disorder eligible for RNP services, 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.

- 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, 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.

Additional Waiver and Expenditure Authorities Being Sought

In addition to the current authorities described above, EOHHS seeks new authorities as summarized in Table 2 below.

Table 2: List of Requested Waiver and Expenditure Authorities

Authority Requested	Description	Waiver Category	Statutory/ Regulatory Citation
Streamlining the Process for Collecting Beneficiary Liability to Decrease Provider Burden and Improve Program Integrity	• EOHHS proposes a new approach to the collection of beneficiary liability; the State 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; methodology for determining the application of beneficiary income to the cost of care will remain the same.	Eligibility	Post Eligibility Treatment of Income 42 CFR 435.725 and 435.726
Medicaid LTSS for Adults with	• Request to strengthen eligibility criteria for group home services for the developmentally disabled	Eligibility	Comparability of Eligibility

Table 2: List of Requested Waiver and Expenditure Authorities			
Authority Requested	**Description**	**Waiver Category**	**Statutory/ Regulatory Citation**
Developmental and Intellectual Disabilities Group Homes	(DD) population receiving HCBS; designed to ensure that the services provided are in the most integrated, least restrictive setting, that the services are appropriate for the needs of the population, and to reduce an over reliance on the most restrictive and highest cost community living option. • Criteria will not be applied to those individuals that are already residing in a group home		Standards Section 1902(a)(17)
Facilitating Medicaid Eligibility for Children with Special Needs	• Establish an eligibility category for children who meet the SSI disability criteria, but whose household income and assets exceed the SSI resource limits. • Allows children who meet the SSI disability criteria and require care in a residential treatment facility to become Medicaid eligible and receive residential care without parents needing to voluntarily relinquish custody to DCYF.	Eligibility	Section 1902(r)(2) of the Act
Covering Family Home Visiting Programs to Improve Birth and Early Childhood Outcomes	• Seeking authority to receive federal matching funds for evidence-based home visiting services for Medicaid-eligible pregnant women and children up to age four who are at-risk for adverse health, behavioral, and educational outcomes are the target population • Aimed at improving maternal and child health outcomes, encourage positive parenting, and promote child development and school readiness	Benefits	Amount, Duration, and Scope Section 1902(a)(10)(B)
Supporting Home- and Community-Based Therapeutic Services for the Adult Population	• Expansion of current in-home/community-based skill building and therapeutic/clinical services for children to 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.	Benefits	Amount, Duration, and Scope Section 1902(a)(10)(B)

Table 2: List of Requested Waiver and Expenditure Authorities			
Authority Requested	**Description**	**Waiver Category**	**Statutory/ Regulatory Citation**
Enhancing Peer Support Services for Parents and Youth Navigating Behavioral Health Challenges	• Request to offer peer mentoring services to children, youth, and young adults, and their families, 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. • 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. • To be claimed under Budget Services 4 for at risk youth	Benefits	Amount, Duration, and Scope Section 1902(a)(10)(B)
Improving Access to Care for Homebound Individuals	• Request 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 routine office-based primary care is not effective because of complex medical, social, and/or behavioral health conditions.	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)
Building Supports for Individuals in a Mental Health or Substance Use Crisis	• Behavioral Health Link (BH Link) triage center to support crisis stabilization and short-term treatment for individuals experiencing a behavioral health or substance use crisis. • Number of providers allowed to provide this service will be limited based on need.	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)

Table 2: List of Requested Waiver and Expenditure Authorities			
Authority Requested	**Description**	**Waiver Category**	**Statutory/ Regulatory Citation**
Providing Clinical Expertise to Primary Care through Telephonic Psychiatric Consultation	• Authority to cover child, adolescent and adult telephonic psychiatric consultation services for primary care practitioners; this is an expansion of the SIM initiative Pediatric Psychiatry Resource Network or "PediPRN" to adults	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	• Seeking to revise the current authority for Community Transition Services by: 1. Characterizing the services as a Preventive service, rather than a Core service; and 2. Expanding the allowable expenses that can be covered under this authority 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); – A short-term supply of food when people transition from the nursing facility or the hospital to the community; and – Transportation from a nursing facility to a new community-based living arrangement.	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)

Table 2: List of Requested Waiver and Expenditure Authorities			
Authority Requested	**Description**	**Waiver Category**	**Statutory/ Regulatory Citation**
Ensuring the Effectiveness of Long-Term Services and Supports	• Request to modify the LTSS expedited eligibility authority by: 1. Using a more efficient, clinical/functional expedited eligibility review process that employs a shortened, concise application that will capture the information (from medical providers) needed to identify individuals who qualify for LTSS; 2. Expanding the benefit package to include Preventive HCBS; 3. Increasing the number of days that adult day care services may be covered from three (3) to five (5) days per week; and 4. 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.	Benefits	Expenditure Authority under 1115(a)(2) of the Act to provide LTC services for individuals who self-attest to financial eligibility factors.

Table 2: List of Requested Waiver and Expenditure Authorities			
Authority Requested	**Description**	**Waiver Category**	**Statutory/ Regulatory Citation**
Modernizing the Preventive and Core Home- and Community-Based Services Benefit Package	• EOHHS seeks to modernize the Preventive and Core Home and Community Based Service (HCBS) package for beneficiaries who meet the applicable clinical/functional criteria by: • Eliminating select HCBS that are no longer needed as they are now State Plan benefits; • Broadening the range of needs-based Preventive and Core HCBS (see list below); • Updating the definitions of the benefits; and • Instituting authority to cap the amount or duration of Preventive HCBS based on need and mandate cost-sharing for Preventive HCBS • New Preventive HCBS include: – Assistive technology – Chore – Community Transition Services – Home stabilization – Limited non-emergency transportation/home visits – Medication management/administration – Peer Supports – Skilled-nursing, when pre-authorized based on need • New Core HCBS include: – Bereavement Counseling – Career Planning – Consultative Clinical and Therapeutic Services – Prevocational Services – Psychosocial Rehabilitation Services – Training and Counseling Services for Unpaid Caregivers	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B) and 1915(c)
DSHP Claiming and Expenditure Authority for a Full Five Years	• Extension of the Designated State Health Program (DSHP) authority through December 31, 2020, allowing continued work on AEs and Healthcare Workforce Development activities through 2022	Delivery System and Expenditure Authority	Expenditure Authority under 1115(a)(2) of the Act for state expenditures for designated state health programs

Table 2: List of Requested Waiver and Expenditure Authorities			
Authority Requested	**Description**	**Waiver Category**	**Statutory/ Regulatory Citation**
Piloting Dental Case Management	• Pilot four new dental case management CPT codes in select group of approximately six trained dental practices across the state • Monitored via claims data from MMIS and a customized data collection form to determine effectiveness prior to full implementation	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	• Waiver of 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 who have mental health or substance use disorders and are participating in residential treatment programs with a census of 16 or more beds that are considered IMDs	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	• Pilot an Alternative Payment Methodology (such as bundled payments, per member per month payments, episodic payments, and quality-adjusted payments) for personal care and homemaker services • Pilot first, then full implementation if evaluation proves successful	Finance and Expenditure Authority	Section 1902(a)(23)(A) of the Act

Enrollment and Expenditure Estimates

As of December 2017, EOHHS's Medicaid program was serving 315,000 enrollees, nearly a third of the State's population. EOHHS Medicaid anticipates stable enrollment and expenditure growth for the foreseeable future as described in the following chart.

		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

Demonstration Eligibility

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 healthcare services, mostly through Medicaid MCOs that are consistently ranked in the top ten in national NCQA rankings for Medicaid MCOs. All eligibility groups covered presently by Medicaid are included within the Rhode Island Section 1115 Comprehensive Demonstration. For 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.

Benefits

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 nine (9) additional benefits that will provide EOHHS Medicaid's more fragile members with greater access to care and requests authority for the benefits detailed in Table 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.

Cost-Sharing

All existing cost sharing authorities will remain in force for the requested five-year extension period as listed in Table 3 below:

Table 3: Current Premium and Cost-Sharing Requirements

Family Income Level	Premium Limits*				
	Children under 1**	Children 1 to 19th birthday**	Adults	Pregnant women	Extended family planning
At least 150 percent but not more than 185 percent FPL	None	Up to 5 percent of family income	Up to 5 percent of family income	None	None
Over 185 percent but not more than 200 percent FPL	None	Up to 5 percent of family income	Up to 5 percent of family income	None	None
Over 200 percent but not more than 250 percent FPL	None	Up to 5 percent of family income	Up to 5 percent of family income	None	None

*No cost-sharing for: pregnant women, children under age one (1), children in foster care or adoption subsidy, Chafee children, Alaskan Native/American Indian children and adults.
** No cost sharing or premiums for children in foster care or adoption subsidy.

Delivery System

All services provided through the Demonstration are administered through one of the following delivery systems based on their payment mechanism-capitated managed care or fee-for-service and source of case/care management.

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)

- For those populations of beneficiaries that do not qualify for enrollment in managed care, they may receive services through the traditional Fee-For Service (FFS) arrangements with providers. Some populations may 'opt-out' of managed care programs and are also eligible to receive services through FFS. Self-direction beneficiaries (or, as they authorize, their families) have the option to purchase HCBS waiver like services through a self-direction service delivery system. Under this option, beneficiaries will work with the agency 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).

Hypothesis and Evaluation Parameters

As further described in Attachment F of the RI 1115 Waiver Extension Request Document, below are the hypotheses of the Demonstration for CY2019 through CY2023. Each hypothesis will be evaluated based on the corresponding measures, also provided below.

Principle 1: Pay for Value, not 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 *EOHHS Total Cost of Care (TCOC) Guidance* Document).
    - Measure 2: Percent of care delivered in the attributed AE.
    - Measure 3: Percent of recipients in an attributed AE using the emergency department annually (Annual ED visit/1,000)
    - Measure 4: Percent of AE enrollees with an inpatient admission (IP) annually (Annual IP admits/1,000)
    - Measure 5: Percent of AE enrollees with an Annual Well Visit (AE Member Visit/1, 000)
    - Measure 6: Percent of AE enrollees that churn overall and churn by AE

Principle 2: Coordinate Physical, Behavioral, and Long-Term Healthcare

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

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.
    - Measure 2: Percent of recipients who score in each level of care at risk for custodial placement.
    - Measure 3: Percent of recipients utilizing the emergency department annually (Annual ED visit/1,000)
    - Measure 4: Percent of recipients with an inpatient admission (IP) annually (Annual IP admits/1,000)