STATE OF RHODE ISLAND
OFFICE OF GOVERNOR DANIEL J. MCKEE

May 13, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Letter of support of Rhode Island's section 1115 demonstration waiver application to extend the Rhode Island comprehensive demonstration

Dear Administrator Brooks-LaSure:

I support the enclosed addendum to Rhode Island's Section 1115 demonstration waiver application to extend the Rhode Island comprehensive demonstration (the addendum). The addendum aims to further the goals described in the state's December 2022 demonstration extension request, particularly with respect to improving behavioral health services and health equity.

In addition, this addendum expands on the demonstration extension request's health-related social needs initiatives by adding nutrition services, a vital social driver of health. Rhode Island also seeks to update the extension request's proposal for pre-release supports for incarcerated individuals by requesting 90 days of pre-release coverage and adding further details regarding covered services. To support improved behavioral health care, this addendum requests authority for a contingency management pilot program.

To continue Rhode Island's efforts to streamline administration of the program and promote transparency of the State's Medicaid program, the addendum also proposes technical changes to the family and youth support partners program and to the portion of the waiver related to home and community-based services.

The requests included in the extension and addendum will advance the objectives of Medicaid. Thank you for your consideration of Rhode Island's 1115 demonstration waiver extension that will improve health outcomes of Rhode Islanders.

Sincerely,

[redacted]

Daniel J. McKee
Governor

Rhode Island Comprehensive Section 1115 Demonstration Waiver Extension Request Addendum

Project No. 11-W-00242/1

May 23, 2024

Contents

Section I: Executive Summary

Rhode Island respectfully submits this addendum request (Addendum) to revise its application to renew the Medicaid Section 1115 Demonstration Waiver (the Rhode Island Comprehensive Demonstration, hereinafter also referred to as "the Demonstration") which was previously submitted to the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS") on December 22, 2022 (the "Extension"). Like the amendment request to allow the provision of Home and Community-Based Personal Care services in acute hospital settings, which was submitted on September 12, 2023, this Addendum aims to support continued progress towards healthy outcomes, quality, and value, with a focus on equity for all populations served by our state Medicaid program.

This Addendum takes advantage of guidance issued by CMS after Rhode Island's submission of the Extension on December 22, 2022, which provides opportunities to expand upon Rhode Island's core priorities, especially pertaining to health-related social needs, equity across the continuum of care, and improving access to high quality behavioral health services. Rhode Island is pursuing this Addendum in furtherance of these priorities and in alignment with CMS' recent approvals of 1115 Demonstration waivers in California and Washington.

This Addendum aims to further the goals described in the Extension, particularly with respect to improving health equity and access to vital behavioral health services. The health-related social needs initiatives in the Demonstration renewal request are expanded in this Addendum to include Nutrition Services, a vital social driver of health. The State also seeks to update the Extension's request for Pre-Release Supports for Incarcerated Individuals by requesting 90 days of pre-release coverage and adding further details regarding covered services. To support improved behavioral health care, this Addendum requests authority for a Contingency Management Pilot Program. Detailed information about the requests put forward in this Addendum can be found in Section II.

In addition to these program enhancing initiatives, Rhode Island is seeking to make technical corrections to the portion of the waiver related to Home and Community-Based Services (HCBS). These requested changes will support the State's efforts to streamline administration of the program and promote transparency of the State's Medicaid program. Detailed information about the proposed technical changes can be found in Section 2.3.

Rhode Island's submission of this Addendum is in furtherance of the State's goals and priorities and continues to leverage the Demonstration as an innovative mechanism to serve Rhode Islanders' health and wellness needs across the lifespan.

Rhode Island requests that this Addendum take effect on or before January 1, 2025, in accordance with the required state statutory timeframes and in alignment with the effective date of the Extension.

Section II: Proposed Additions

Rhode Island's goals for this Addendum are aligned with the goals in the Demonstration Extension (Extension) submitted on December 22, 2022:

- Goal 1: Health Equity: Improve health equity through strong community-clinical linkages that support beneficiaries in addressing social determinants of health, including ensuring access to stable housing.

- Goal 2: Behavioral Health: Continue to ensure expanded access to high-quality integrated behavioral healthcare that is focused on prevention, intervention, and treatment.

- Goal 3: Long-Term Services and Supports (LTSS): Continue progress toward rebalancing LTSS toward home and community-based services (HCBS).

- Goal 4: Maintain and Expand on Our Record of Excellence: Streamline administration of the Demonstration to strengthen current services and processes, while supporting continued progress toward our state's goals of improving healthcare quality and outcomes for Medicaid beneficiaries.

This Addendum builds upon these goals by:

1. Requesting program enhancements to support health equity:
    a. Nutrition Services, consistent with recent Health-Related Social Needs authorities approved in state 1115 Demonstration Waivers
    b. Additional details related to Rhode Island's Extension request for Pre-Release for Incarcerated Individuals
2. Requesting program enhancements and technical updates to support behavioral health:
    a. Contingency Management Pilot Program that will support substance-use disorder treatment, consistent with recent authorities approved in state 1115 Demonstration Waivers
    b. Update the provider qualifications for Family and Youth Support Partners
3. Requesting technical changes to Home and Community-Based Services authorities:
    a. Preventive HCBS
    b. Technical Changes to Attachment B Services

This Addendum seeks to update the pending Demonstration Extension submitted on December 22, 2022 and is expected to take effect simultaneously with the Extension on January 1, 2025, or other date as approved by CMS.

2.1 Health Equity Program Enhancements

In the time since Rhode Island developed the Extension submitted in December 2022, CMS has shared new opportunities and guidance related to health equity efforts. This includes details on Health-Related Social Need services such as Nutrition Services and significant guidance on the scope of the Reentry 1115 Demonstration Opportunity. Rhode Island welcomes this opportunity to request new authority for Nutrition Services and to add further detail to the state's existing request for Pre-Release/Reentry Medicaid in alignment with the new information made available in recent months.

2.1.1 Nutrition Services

As stated during the White House Conference on Hunger, Nutrition and Health in September 2022 "the lack of access to healthy, safe, and affordable food contributes to hunger, diet-related diseases, and health disparities." Diet related diseases like type 2 diabetes, often exacerbated by food insecurity, are some of the leading causes of death and disability in the United States,

and disproportionately impact marginalized communities.[1] In recognition of the growing body of evidence, Rhode Island seeks to join CMS and other state Medicaid programs in testing food as medicine initiatives to achieve positive health outcomes for our beneficiaries and disrupt the cycle of food and nutrition health inequities.

In the "2022 Status Report on Hunger in Rhode Island" the Rhode Island Community Food Bank reported that nearly 1/3 of Rhode Islanders can't afford adequate food.[2] In analyzing the disaggregated data, the risks related to hunger are rising for communities of color and low-income families with children. These risks, compounded by the impacts of COVID-19 and the growing burden of food cost inflation, can be ameliorated by a pragmatic approach to addressing the nutritional needs of the most impacted Rhode Island Medicaid beneficiaries.

In determining the populations most in need of nutrition services, the RI Life Index indicates that people of color are much more likely to be food insecure than White people. Specifically in 2022, 23% of white households in Rhode Island were food insecure, whereas 43% of black households and 47% of Latino households were food insecure. Of additional concern is that the disparity between white households and households of people of color continues to grow year over year.[3] We also know that people of color face inequities related diet-related diseases, exacerbating the need for a nutrition-based intervention to address both the individual health needs of those with related diseases, like diabetes, but also as a meaningful tactic to improve health equity.

Of additional concern for Rhode Island is the high prevalence of food insecurity in low-income families with children, many of whom are Medicaid beneficiaries. In 2022, per the RI Life Index, 41% of low-income families were food insecure, growing from 25% in 2021. This dramatic rise in hunger for financially strained families with children has serious consequences, since poor nutrition adversely impacts children's health, growth, and learning.[4]

Given this data, Rhode Island proposes to focus its nutrition services on those impacted by diet-related diseases and families with children facing food insecurity. In reviewing food is medicine initiatives with a strong or growing evidence base, two benefits stand out as being effective pathways to improving adequate nutrition for Rhode Island's target populations: healthy food prescriptions and medically tailored meals.

Healthy food prescriptions in the form of vouchers were found in a 2019 study that modeled the impact of subsidizing healthy food for Medicare and Medicaid beneficiaries to be 'more cost effective as other common interventions, such as preventative drug treatments for hypertension

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[1] White House Conference on Hunger, Nutrition, and Health. Retrieved October 6, 2023, from https://health.gov/our-work/nutrition-physical-activity/white-house-conference-hunger-nutrition-and-health.
[2] Rhode Island Community Food Bank. (2022). 2022 Status Report on Hunger in Rhode Island. Retrieved October 4, 2023, from https://rifoodbank.org/wp-content/uploads/2023/07/2022-RICFB-StatusReport-final-web.pdf
[3] Blue Cross & Blue Shield of Rhode Island and Brown University School of Public Health. (2022). RI Life Index. Retrieved October 4, 2023, from https://www.rilifeindex.org/.
[4] Pai, S., & Bahadur, K. (2020). The Impact of Food Insecurity on Child Health. *Pediatric Clinics of North America*, *67*(2), 387–396. Retrieved October 6, 2023, from https://doi.org/10.1016/j.pcl.2019.12.004.

or high cholesterol."[5] Medically-tailored meals have been shown to also reduce healthcare utilization and improve outcomes.[6] Given the evidence base, Rhode Island seeks to address the risks associated with rising hunger and inadequate nutrition for the populations as defined by leveraging these two services similar to approved HRSN services in recent Medicaid 1115 waivers and SSBCI benefits under Medicare Part C.

1. Healthy Food Prescriptions

This service consists of nutritionally appropriate food prescriptions provided as nutrition vouchers or food boxes (picked up or home-delivered) based on the preference and needs of the eligible beneficiary. Healthy Food Prescriptions are designed to supplement daily food needs for food-insecure individuals and families and do not constitute a person's full nutritional regimen, defined as three meals per day per person. Healthy Food Prescriptions may include, but are not limited to, prescription fruit and vegetable programs.

For beneficiaries who choose to receive this service as a food box, food box items will be one of two types, depending on the beneficiary's needs: "general" groceries and therapeutic groceries selected to be appropriate for a beneficiary with a particular nutritional need (e.g., low sodium). Both general and therapeutic groceries need to include culturally preferred foods to meet the needs of individuals based on their cultural identity (e.g., Halal or Kosher meals). Small or large boxes will be available based on family size.

Rhode Island proposes that this service be available for six months with the option for the service to be reauthorized every six months thereafter based on whether the beneficiary continues to meet eligibility criteria.

To be eligible for Healthy Food Prescriptions, beneficiaries must be experiencing food insecurity as determined by a service provider or a related screening tool and be:

- A family with a child(ren) under 6; and/or
- Pregnant/post-partum; and/or
- Experiencing a chronic disease, including any of the following: failure to thrive, slowed/faltering growth pattern, gestational diabetes, pre-eclampsia, HIV/AIDS, kidney disease, liver disease, diabetes/pre-diabetes, cardiovascular disease, COPD, stroke, celiac disease, severe food allergies, or cancer.

Rhode Island proposes to use a prior authorization requirement to ensure that the service is properly targeted to eligible beneficiaries. The prior authorization will include information on the determination of food insecurity by a service provider or the appropriate food insecurity related screening tool as well as information on the additional eligibility criteria above.

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[5] Lee, Y., Mozaffarian, D., Sy, S., Huang, Y., Liu, J., Wilde, P. E., Abrahams-Gessel, S., Jardim, T. de S. V., Gaziano, T. A., & Micha, R. (2019). Cost-effectiveness of financial incentives for improving diet and health through Medicare and Medicaid: A microsimulation study. *PLoS Medicine*, *16*(3), e1002761. Retrieved October 6, 2023, from https://doi.org/10.1371/journal.pmed.1002761.

[6] Berkowitz, S. A., Terranova, J., Randall, L., Cranston, K., Waters, D. B., & Hsu, J. (2019). Association Between Receipt of a Medically Tailored Meal Program and Health Care Use. *JAMA Internal Medicine*, *179*(6), 786. Retrieved October 6, 2023, from https://doi.org/10.1001/jamainternmed.2019.0198.

2. Medically Tailored Meals

A “Medically Tailored Meal” is a home-delivered meal that is medically tailored for a specific disease or condition.

The service includes:

- An initial evaluation with a Licensed Dietitian to assess and develop a medically appropriate nutrition care plan. The nutrition assessment can be conducted in person, in a clinic environment, the enrollee’s home, or telephonically as appropriate.
- The preparation and delivery of the medically tailored meal. Meals must be developed in accordance with nutritional guidelines established by the National Food Is Medicine Coalition or other appropriate guidelines approved by EOHHS. Meals may be tailored to meet cultural preferences.
- Regular reassessment by a Licensed Dietician at least once every 3 months, unless the prescribing clinician identifies, as part of the prior authorization request, that the individual requires less frequent reassessment, at a minimum frequency of every 6 months.

Meal delivery services will differ based on the severity of need. On average, individuals receive two (2) meals per day.

Rhode Island proposes that individuals continue to receive the service so long as they continue to meet eligibility criteria and the service is still needed as indicated by the regular reassessment.

To be eligible for Medically Tailored Meals, beneficiaries must:

- Lack the capacity to shop and/or cook for themselves as well as adequate supports to meet these needs; and
- Be diagnosed with a chronic disease, including any of the following: failure to thrive, slowed/faltering growth pattern, gestational diabetes, pre-eclampsia, HIV/AIDS, kidney disease, liver disease, diabetes/pre-diabetes, cardiovascular disease, COPD, stroke, celiac disease, severe food allergies, or cancer.

Rhode Island proposes to use a prior authorization requirement to ensure that the service is properly targeted to eligible beneficiaries.

2.1.2 Pre-release Supports for Incarcerated Individuals

In its Extension request, Rhode Island sought to obtain authority to provide an array of pre-release services to incarcerated individuals. Rhode Island still seeks to implement these services but with modifications based on subsequent developments in state and federal policy. First, Rhode Island seeks to update the state’s request for pre-release supports to include 90 days of pre-release coverage rather than 30 days. As the state has continued preliminary planning work, it has become clear that the complexities of re-entry planning are such that more time is needed to maximize the value of these services for those preparing for release from a sentenced status.

For those awaiting trial, there is substantial uncertainty regarding release timing for each individual. However, the average length of stay before being sentenced or released is 31 days, and the median length is five days. Therefore, the state plans to provide 30 days of the Medicaid services listed below upon (pre-trial) entry into the correctional facility. Providing these

services to this population is essential, because a) approximately 80% are released rather than sentenced, meaning that they are experiencing a re-entry and will benefit from these supports in the same way that a person released from a sentenced status will; and b) both for those who are released and those who are sentenced, the screening and diagnosis services will identify health needs that the individual may not be aware of and allow for appropriate planning for their care, either in the community or within the carceral setting.

In addition, Rhode Island is leveraging this Addendum to provide additional details related to pre-release supports requested in the Extension given the subsequent guidance from CMS.

Rhode Island is aware that pre-release supports must include coverage for three benefits: targeted case management, medication assisted treatment (MAT), and the provision of 30 days of prescription medications at the time of release. States are given discretion regarding additional services to be included in pre-release supports, eligibility criteria for the benefit, and the timeframe that the benefit is offered.

Rhode Island is requesting pre-release supports coverage for all Medicaid eligible individuals. The reason for including all Medicaid-eligible individuals is the state's desire for all Medicaid beneficiaries exiting a correctional facility, including juvenile detention, to have the appropriate support, services and care to make a successful transition back to communities. Given Rhode Island's small correctional population and the likelihood that most Medicaid-eligible individuals would meet any health-related criteria imposed, the state believes this is an efficient and reasonable approach.

In addition to the three required pre-release services, the state proposed to include the following services as Medicaid pre-release supports:

1) *Dental Services*
2) *Durable Medical Equipment*
3) *Family Home-Visiting Services*
4) *Family Planning Services, including but not limited to Long-Acting Reversible Contraception*
5) *Home Stabilization Services*
6) *Laboratory and radiology services*
7) *Medications and medication administration during the pre-release period*
8) *Optometry*
9) *Physical and behavioral health clinical consultation services, including physician services, provided through telehealth or in person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning.*
10) *Services provided by Community Health Workers and Peer Recovery Specialists*

Rhode Island believes that these services will substantially contribute to the success of re-entry into the community by 1) addressing key health issues before release so that the individual does not need to immediately address them post-release (e.g., dental concerns, family planning needs, diagnosing and beginning treatment for conditions, establishing medication regimes, providing access to glasses and DME needed to function effectively in the community); and 2) making connections to key post-release providers to ease the transition (Home Stabilization, Community Health Workers, Peer Recovery Specialists, Family Home Visiting Services).

2.2 Behavioral Health Enhancements and Technical Updates

In addition to the health equity initiatives discussed above, CMS also approved a new behavioral health initiative in the months following Rhode Island's Extension submission. The state welcomes the new opportunity to implement a Contingency Management Pilot Program, described below, to further the state's efforts to address the opioid epidemic and the challenge posed by rising stimulant use.

Rhode Island also seeks a technical change to enhance access to Family and Youth Support Partners by updating the provider qualifications for the program and clarifying the support partner roles.

2.2.1 Contingency Management Pilot Program

Rhode Island continues to experience substantial challenges due to the opioid epidemic, and opioid overdose remains the leading cause of accidental death in the state. According to the Rhode Island Department of Health Drug Overdose Surveillance Data Hub, in 2019 through 2022 respectively, 308, 384, 435, and 434 Rhode Islanders died as a result of drug overdoses.[7]

In addition, Rhode Island is also experiencing increasing challenges with stimulant use disorders. In a 2022 Harm Reduction Surveillance System survey[8] conducted by the Rhode Island Department of Health, crack cocaine was the most reported non-prescribed substance respondents had used in the previous 30 days: 73% of respondents had used crack cocaine in that time, while 42% had used cocaine powder. Another 28% had used methamphetamine. This is particularly dangerous because of the frequency with which cocaine is contaminated with fentanyl; in the same survey, 55% of those who believed they unexpectedly used fentanyl while using other substances did so while using either crack or powder cocaine. Likely due in part to the involvement of fentanyl, the proportion of fatal overdoses involving cocaine has increased dramatically over time, from 26% in 2009 to 53% in 2021. Similar patterns are emerging for amphetamines and methamphetamines; by 2021, 19% of fatal overdoses in the state involved amphetamines and/or methamphetamines.

In addition to being a general issue of public health and safety, rising cocaine use is a significant health equity issue for Rhode Island. The rate of fatal cocaine overdose is twice as high among the Black, non-Hispanic population than the white, non-Hispanic or Hispanic/Latino populations.

Rhode Island has identified an opportunity to enhance substance use disorder (SUD) treatment for Medicaid beneficiaries: contingency management. As explained by SAMHSA,[9] contingency management (CM) "is a well-known behavioral intervention designed to increase desired behaviors by providing immediate reinforcing consequences (in the form of incentives) when the

[7] Rhode Island Department of Health. Drug Overdose Surveillance Data Hub. Retrieved October 10, 2023, from https://ridoh-drug-overdose-surveillance-fatalities-rihealth.hub.arcgis.com/.
[8] Ledingham, E. M., McKenzie, M., McKee, H., St John, K., Rodriguez, M., Reichley, N., & Hallowell, B. D. (2023). Preliminary findings from the Rhode Island Harm Reduction Surveillance System: January 2021-December 2022. *Rhode Island Medical Journal (2013)*, *106*(3), 70–73. Retrieved October 10, 2023, from https://pubmed.ncbi.nlm.nih.gov/36989103/.
[9] Substance Abuse and Mental Health Services Administration. Treatment for Stimulant Use Disorders - Treatment Improvement Protocol TIP 33. (2021). Retrieved October 10, 2023, from https://store.samhsa.gov/sites/default/files/pep21-02-01-004.pdf.

target behavior occurs, and withholding those incentives when the target behavior does not occur, but not in a punitive manner. CM has been used with considerable effectiveness in treating individuals with a variety of SUDs and is very useful for treatment planning because it sets concrete short- and long-term goals and emphasizes positive behavioral changes." CM is highly effective for individuals with opioid use disorder[10] and "CM interventions have by far the greatest amount of empirical support for their efficacy in promoting therapeutic behavioral change among people with stimulant use."

Rhode Island proposes to add a new Contingency Management Pilot Program to serve as another, critical tool in our efforts to support recovery efforts for Rhode Islanders with substance use disorders.

The CM benefit will consist of a series of motivational incentives for meeting treatment goals, such as non-use of substances or treatment/medication adherence as evidenced by, for example, negative drug tests. These motivational incentives are central to CM, based on the best available scientific evidence for treating a substance use disorder and will not be used as an inducement to use other medical services. CM will be offered along with other therapeutic interventions, such as cognitive behavioral therapy, motivational interviewing and medication assisted treatment as clinically appropriate. Motivational incentives will be managed and disbursed through a mobile or web-based incentive management software program that includes strict safeguards against fraud and abuse.

CM will be available only when it is medically necessary and appropriate. CM should never be used in place of medication treatment for opioid use disorder.

To qualify for the CM benefit, Medicaid beneficiaries must:

1. Be enrolled in a comprehensive Rhode Island Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) licensed treatment program that offers other services (e.g., group or individual therapy) delivered in person or via telehealth.
2. Be assessed and determined to have an alcohol and/or substance use disorder for which the CM benefit is medically appropriate based on the fidelity of treatment to the evidence-based practice.

Providers must meet specified programmatic standards set by the Rhode Island Department of Behavioral Health, Developmental Disabilities, and Hospitals. Staff providing CM services will need to have documentation that they have been trained by a qualified trainer to deliver CM services.

The following practitioners delivering care at qualified provider sites can deliver the CM benefit: Licensed Practitioners; and SUD counselors that are either certified or registered by an organization that is licensed by BHDDH and accredited with one of the National Commission Certifying Agencies such as CARF or JACHO. Practitioners may engage in activities such as

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[10] Bolívar, H. A., Klemperer, E. M., Coleman, S. R. M., DeSarno, M., Skelly, J. M., & Higgins, S. T. (2021). Contingency Management for Patients Receiving Medication for Opioid Use Disorder. *JAMA Psychiatry*, *78*(10), 1092. Retrieved October 10, 2023, from https://doi.org/10.1001/jamapsychiatry.2021.1969.

administering point-of-care urine drug tests, informing beneficiaries of the results of the evidence/urine drug test, entering the results into the mobile or web-based application, providing educational information, and distributing motivational incentives.

SUD providers will be required to offer accompanying SUD treatment services and evidence-based practices for a substance use disorder and any other co-occurring substance use disorder in addition to CM services. These services may include individual, group and/or family counseling using a range of applicable evidence-based modalities and techniques, including but not limited to cognitive behavioral therapy, community reinforcement, motivational interviewing, care coordination, peer support services, medications for addiction treatment, recovery supports, withdrawal management, medication services, and patient education.

Providers must also agree to provide the benefit in accordance with standardized procedures and protocols established by EOHHS and BHDDH and approved by CMS.

2.2.2 Family and Youth Support Partners Technical Change

Rhode Island seeks to update the provider qualifications for Family and Youth Support Partners to clarify the support partner roles. This important benefit has been shown to facilitate recovery, reduce stress for parents and caregivers and increase social supports.[11]

The state proposes the following provider qualifications:

Qualifications for Family Partners:

- Must be 21 years of age;
- Self-identified parent or caregiver of a child or youth with special needs, including behavioral health needs, and/or a child involved in the child welfare or juvenile justice systems OR professional experience of at least two years working with children/ youth with special needs OR be equivalently qualified by education in the human services field; and
- Minimum of a high school diploma or GED.

The Family Partner must be supervised by a licensed mental health professional, who is available at all times to provide support and consultation.

Qualifications for Youth Partners:

- Must be 21 years of age; and
- Have a high school diploma or equivalent with 2 years of experience working with children/ youth OR a relevant Associates degree with 1 year of experience working with children/ youth OR a Bachelors degree in a relevant field.

[11] https://qucchdtacenter.georgetown.edu/resourcesSubstance Abuse and Mental Health Services Administration. (January 2019). *Recovery and recovery Support | SAMHSA - Substance Abuse and Mental Health Services Administration*. Retrieved October 10, 2023, from https://www.samhsa.gov/find-help/recovery.

The Youth Partner must be supervised by a licensed mental health professional, who is available at all times to provide support and consultation.

2.3 Home and Community-Based Services Technical Changes

Rhode Island has continued the state's efforts, begun in the Extension submitted in December, to ensure accuracy and clarity in Attachment B, which lists the state's Home and Community Based Services (HCBS). The changes described in this section will not alter or reduce the services currently delivered to Medicaid beneficiaries, but rather are intended to accurately describe the source of authority for the services currently delivered (e.g., the state plan rather than the waiver) and to remove references to services that have not been implemented.

2.3.1 Preventive HCBS

The state's current 1115 waiver authorizes Rhode Island to provide "Preventive home and community-based services" to individuals who do not meet an institutional level of care but for whom a given "Preventive" service would prevent admission, re-admission, or length of stay at an institution.

As explained in the Extension, a number of these Preventive services are available both under the waiver and under the state plan. Therefore, the criteria to receive these services vary based on the authority through which they are delivered. The Preventive HCBS services available under the state plan are made available on the basis of medical necessity, without a formal "level of care" determination of the kind used to determine "High" and "Highest" levels of care for LTSS. This has made required HCBS reporting administratively complex and difficult because it is not possible to differentiate between those individuals receiving the service pursuant to the state plan and those receiving the service pursuant to the waiver – that is, to differentiate between those receiving the service for an explicitly "preventive" reason from those receiving the service for any other medically necessary reason.

Additionally, the Preventive services listed in the waiver that are not included in the state plan have not been implemented to date, due to a lack of state legislative spending authority. The continued presence of these services as listed Preventive HCBS services may create confusion for participants and others regarding the scope of coverage and is not permitted under federal HCBS guidelines.

In order to ensure clarity and compliance with all HCBS requirements, Rhode Island requests to eliminate the Preventive HCBS benefit category under the waiver. This will include elimination of the Preventive level of care as well as the Preventive segment of Attachment B.

As described in more detail below, this change is intended to more accurately reflect current program operations, and will not impact access to services.

- Each of the Preventive benefits that are currently delivered to the non-LTSS population are already authorized through the state plan and will continue to be available on the same terms as they are available currently.

- The Preventive benefits that are not currently implemented for the non-LTSS population do not have budget authority from the Rhode Island legislature for implementation and therefore are not permitted to remain listed as HCBS benefits.

Preventive Services for which an Identical Service is Available Through the State Plan

The following services are already available through the state plan and will continue to be authorized through the state plan, as described here:

1. Certain examples of Assistive Technology will continue to be covered as Home Health benefits to the same extent currently available under the Preventive benefit, under the category of medical supplies, equipment and appliances (i.e., Durable Medical Equipment).
2. Personal Care, Physical Therapy, and Skilled Nursing are covered state plan benefits.
3. Homemaker Services will continue to be covered as a Home Health benefit.
4. Medication Management/Administration will continue to be covered as a physician service.

Preventive Services that Have Not Been Implemented for the Non-LTSS Population

1. PERS: The PERS benefit was not implemented for the Preventive population and therefore is not permitted to remain listed as an HCBS for this population. EOHHS plans to work with CMS and managed care plans to offer PERS as a managed care in-lieu of service, which is expected to enhance access for non-LTSS beneficiaries relative to the status quo.

2. Peer Support: The Peer Support benefit has not been operationalized for the Preventive population and therefore is not permitted to remain listed as an HCBS for this population. EOHHS understands that Peer Support is a distinct service, but believes it is important to emphasize the potential value of a related service that is available through the state plan: the Community Health Worker (CHW) benefit. CHWs can bring lived experience in managing a health condition to support learning healthy living skills – in fact, Health Promotion and Coaching is a specific CHW service component. In the event that EOHHS receives state budget authority to implement the Peer Support service for non-LTSS beneficiaries, EOHHS would work with CMS to determine the most effective authority pathway for implementation.

3. Chore Service: The Chore Service benefit has also not been operationalized for the Preventive population – nor, as discussed below, has it been operationalized for individuals meeting the “High” or “Highest” level of care. At this time, EOHHS does not have state legislative authority to implement the Chore Service for any population. Because this service was never implemented, the removal of the Chore Service from the waiver will not have a negative impact on the availability of services for any population. In the event that EOHHS receives state budget authority to implement the Chore Service for non-LTSS beneficiaries, EOHHS would include it within the state plan as a Home Health benefit.

4. Community Transitions: The Community Transitions benefit has not been implemented for the non-LTSS population and therefore is not permitted to remain listed as an HCBS for this population. EOHHS notes that the service is designed for individuals transitioning from an institutional or other provider-operated living arrangement to a private residence. This is not a circumstance that would be expected to arise for individuals who do not meet an LTSS level of care, because it is unlikely that a person

not demonstrated to meet the LTSS level of care would be living in an institutional or other provider-operated living arrangement.

5. Non-Medical Transportation: This service has not been implemented for the non-LTSS population and therefore is not permitted to remain listed as an HCBS for this population. EOHHS notes that this service is to assist individuals to access HCBS services and other services specified in the person's service plan. Individuals who do not meet an LTSS level of care do not receive HCBS services or have service plans.

6. Respite: Respite has not been implemented for the non-LTSS population and therefore is not permitted to remain listed as an HCBS for this population.

7. Home-Delivered Meals: This service has not been implemented for the non-LTSS population and therefore is not permitted to remain listed as an HCBS for this population. EOHHS expects that some non-LTSS beneficiaries may benefit from the proposed addition of nutrition services described above, to serve a more targeted population for whom nutrition services are medically necessary. Home-Delivered Meals, which has been authorized in the state budget and implemented for LTSS, will remain available for the LTSS population. Home-delivered meals may also be offered to non-LTSS managed care members as an in-lieu of service.

As described above, these changes will not affect the services currently being delivered. The changes are intended solely to ensure accuracy and clarity of the waiver and support administrative efficacy and compliance for HCBS reporting. Rhode Island is committed to continuing to deliver high-quality services that can assist in avoiding institutionalization.

2.3.2 Other Technical Changes to Attachment B

In Rhode Island's current waiver, Attachment B states that it lists "Core, Preventive, and Therapeutic Home and Community-based Service Definitions." As explained above, the state is requesting to eliminate the "Preventive" section. In addition, the state requests several other changes to maximize clarity and accuracy of Attachment B. The state's goal is to ensure that Attachment B accurately documents Rhode Island's active and operationalized LTSS HCBS services. This is important both for general clarity and because the state has specific compliance requirements for HCBS services that do not apply to other services.

The changes requested below will not change the services currently available to LTSS HCBS participants.

This section lists EOHHS requests to modify or remove certain services from Attachment B and states the reasons for each change. In some cases, the state is requesting to move the service from Attachment B to another part of the waiver to clarify that the service is not part of HCBS. In other cases, the state seeks to remove the service from the waiver entirely, either because it is duplicative of a state plan service (and therefore does not belong in the waiver) or because the service has not been implemented and therefore is not permitted to remain in Attachment B.

As noted above, no participant will lose access to any service they have received or could receive as a result of these changes.

This table summarizes the proposed changes, which are described in more detail below:

Service	Proposed Change	Reason for Change	Service Delivery Outcome
Coordinated Specialty Care	Move from Attachment B	Not an HCBS service	Non-HCBS 1115 authority will continue
Home Stabilization	Move from Attachment B	Not an HCBS service	Same access will continue under 1115 non-HCBS authority
Consultative Clinical and Therapeutic Services	Add “to paid caregivers” to definition	Technical correction	Same access will continue under Attachment B
Day Treatment and Supports	Replace with separately enumerated therapeutic services	Not offered as a single service/ program bundle. Some listed services are state plan services.	Same access will continue under combination of Attachment B and state plan
Special Equipment and Supplies	Remove from waiver	State plan service	Same access will continue under the state plan
Environmental Modifications/ Home Accessibility Modifications	Remove from waiver	State plan service	Same access will continue under the state plan
Minor Environmental Modifications	Remove from waiver	State plan service	Same access will continue under the state plan
Medication Management/ Administration	Remove from waiver	State plan service	Same access will continue under the state plan
Psychosocial Rehabilitation	Remove from waiver	State plan service	Same access will continue under the state plan
Home and Community-Based Therapeutic Services: Home-Based Treatment, Life skill building services, Case management, Treatment Coordination, Seven Challenges, Family Education and Support/ Health Promotion	Remove from waiver	State plan and other waiver services	Same access will continue under the state plan and other waiver services

Bereavement Counseling	Remove from waiver	Never implemented	If state budget authorizes implementation, state will seek federal authority and implement as approved
Chore Services	Remove from waiver	Never implemented	If state budget authorizes implementation, state will seek federal authority and implement as approved
Training and Counseling for Unpaid Caregivers	Remove from waiver	Never implemented	If state budget authorizes implementation, state will seek federal authority and implement as approved
Prevocational Services	Remove from waiver	Currently implemented as part of other HCBS services	Same access will continue through other HCBS services

Rhode Island requests that the following services be moved from Attachment B to another location in the waiver because they are not HCBS services:

1. Coordinated Specialty Care. This is a behavioral health service that is not currently being delivered through Medicaid but rather is funded through a time-limited grant. The state does anticipate seeking state budget authority to implement this as a Medicaid benefit during the coming waiver period. If the service is authorized, the service will be delivered on the basis of medical necessity and will not be operationalized as an HCBS benefit. Moving this service from Attachment B will not impact access for HCBS participants.
2. Home Stabilization Services. Rhode Island requests that this service be removed from Attachment B because it appears to have been included in the list of HCBS services in error. Home Stabilization is already properly identified as Budget Service 12 in the current Waiver. Removing Home Stabilization from Attachment B will not affect participant access to this service as it is fully documented elsewhere in the waiver already.

Rhode Island requests that the following services be modified:

1. Consultative Clinical and Therapeutic Services: Rhode Island requests that this service definition be revised to include assistance to *paid support staff*, as well as *unpaid*

caregivers, in carrying out individual treatment/support plans. This language aligns with the definition of this service in the HCBS Technical Guide and will support paid support staff in effectively carrying out individual treatment/support plans. The state believes the exclusion of the word “paid” was an error and seeks to correct it now.

2. Day Treatment and Supports: Rhode Island requests changes to more accurately reflect how these services are delivered. The state has not implemented a service bundle or program composed of the services listed under Day Treatment and Supports, but does offer a number of the listed services separately.

   Therefore, Rhode Island requests that “Day Treatment and Supports” be *replaced* by the following, separately enumerated, services:

   a. Individual, Family, and Group Therapy

      The purpose of this service is to maintain the individual's condition and functional level. Therapy will be provided by physicians, psychologists, and/or other mental health professionals to the extent authorized under State law. Family therapy will be provided only when the primary purpose is treatment of the individual’s condition.

   b. Occupational Therapy, Physical Therapy, and Speech-Language Therapy

      The purpose of these services is to maintain the individual's condition and functional level. Services will be delivered by Occupational Therapists, Physical Therapists, and Speech-Language Pathologists (also known as Speech Therapists), respectively.

   c. Behavior Analysis and Management

      Behavior analysis and management includes development, implementation, and monitoring of individually designed plans to address challenging behaviors (Behavior Plans). The service includes direct observation and assessment of the individual’s behaviors in different settings in order to identify behavior “triggers,” and identifying the behavioral techniques that constitute the most effective treatment for each individual. It also includes periodic reassessment and modification of the Behavior Plan, as needed. This service will be provided by Board Certified Behavior Analysts or Board Certified Assistant Behavior Analysts.

   Of the other services listed under Day Treatment and Supports, several are the same as the services available under the state plan and therefore do not need to be listed in the waiver, including:

   - 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, and
   - Diagnostic services.

   “Individual activity therapies” and “Training and education of the individual” are both available in the context of Residential Habilitation and Supports and Integrated Day Habilitation and Supports and therefore do not need to be separately enumerated.

Rhode Island requests that the following services be removed from the waiver because they are or will be covered under the state plan or other waiver services:

1. The following services are all covered under the state plan Durable Medical Equipment benefit:
    a. Special Medical Equipment and Supplies
    b. Environmental Modifications/Home Accessibility Modifications
    c. Minor Environmental Modifications
2. Medication management/administration is covered under the state plan physician services benefit.
3. Psychosocial Rehabilitation Services is covered as a service under the state plan Rehabilitation benefit.
4. The following adult Home and Community-Based Therapeutic Services, which are or will be delivered through a variety of state plan services (e.g., Assertive Community Treatment, CCBHC) and the Peer Recovery Specialist service authorized under the waiver:
    a. Home-Based Treatment
    b. Life skill building services
    c. Case management (as described under HBTS)
    d. Treatment Coordination
    e. Seven Challenges (the state plans to make Seven Challenges available as an evidence-based practice through the CCBHC benefit in 2024)
    f. Family Education and Support/Health Promotion

The reason to remove these state plan services from the waiver is that it is not appropriate to include state plan services in the list of HCBS. For all of these services, HCBS participants will continue to have the same access to this service as they currently do.

Rhode Island requests that the following services be removed from the waiver because the state has not implemented them and currently lacks state budget authority to do so:

1. Bereavement Counseling
2. Chore Services (note that if authorized by the legislature to provide this service for both LTSS and non-LTSS populations, EOHHS would request to amend the State Plan Home Health benefit rather than the waiver)
3. Training and Counseling for Unpaid Caregivers
4. Prevocational services. This is no longer delivered as a separate service with its own rates etc. Rather, participants access prevocational supports through Integrated Supported Employment and Integrated Day Habilitation. The state believes that in the interests of clarity, this should not be listed as a distinct service, but this change will not impact access to support needed to prepare for employment.

The reason to remove these state plan services from the waiver is that Attachment B should only list services that the state has implemented and delivers to participants as distinct HCBS

services. The removal of these services from the waiver will not impact access to services, because these are not currently delivered. If EOHHS receives state budget authority to implement these services in the future, the state will request to amend the waiver to add them back to Attachment B and implement them.

As with the changes to the Preventive HCBS segment of Attachment B, these changes will not change current access to services but rather are intended to ensure accuracy and clarity in the state's waiver. Rhode Island remains committed to delivering robust a HCBS program.

Section III: Anticipated Impact

3.1 Impact to Eligibility

Rhode Island is proposing to make one change to eligibility through this Section 1115 Demonstration extension request Addendum: Rhode Island seeks to provide Medicaid coverage for incarcerated individuals for 90 days before their release from incarceration.

The Rhode Island Department of Corrections releases an estimated 2,000 individuals from a "sentenced" status annually, and an estimated 6,400 from "awaiting trial" status. The state assumes for purposes of this calculation that each person released from a sentenced status will receive 90 days of pre-release coverage, including, as applicable, 30 days during their pre-trial period. This yields a total of approximately 6,000 additional member months annually. For the "awaiting trial" population, 30 days of pre-release coverage will yield 6,400 additional member months annually. The total across both the "sentenced" and "awaiting trial" populations is therefore an estimated 12,400 member months per year.

3.2 Impact to Delivery System

Rhode Island is not proposing any changes to the Medicaid delivery system through this Section 1115 Demonstration extension request Addendum.

3.3 Impact to Covered Benefits/Cost Sharing

The Addendum will:

- Increase access to new services, including Nutrition Services and CM
- Not decrease access to any existing services, because:
    - All implemented "Preventive HCBS" services are and will remain available either through the state plan or other waiver authorities; and
    - The Attachment B "Core" and "Home and Community-Based Therapeutic Services" the state requests to remove from the waiver are already available through the state plan, will be made available through the state plan through upcoming state plan Amendments, or have not been implemented.

Rhode Island is not proposing any changes to cost sharing.

Section IV: Requested Waivers and Expenditure Authority

The State is requesting the following waiver and expenditure authorities to implement the new and enhanced programs and services under this Addendum.

Authority Requested	Waiver Category	Statutory/Regulatory Citation
Waiver Authorities		
Health-Related Social Need Services	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)
Contingency Management Pilot	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)
Expenditure Authorities		
Provide Coverage for Incarcerated Individuals 90 Days Prior to Release	Eligibility	Expenditure Authority under 1115(a)(2) of the Act (CNOM)
Health-Related Social Need Services	Benefits	Expenditure Authority under 1115(a)(2) of the Act (CNOM)
Contingency Management Pilot	Benefits	Expenditure Authority under 1115(a)(2) of the Act (CNOM)

Rhode Island is not seeking to modify any other provisions in the currently approved RI Section 1115 Demonstration through this Addendum.

Section V: Evaluation and Program Oversight

5.1 Evaluation and Demonstration Hypothesis

90-Day Enrollment Pre-release for Incarcerated Individuals

Evaluation Approach: As described in the Extension request for 30-day enrollment pre-release, we will use descriptive statistics to characterize participation in pre-release supports, including the number served, demographics, and socioeconomic characteristics, and evaluators propose to conduct a one-group post-test analysis comparing outcomes for participants before and after receiving services. The following hypotheses and measures, already described in the Extension request for 30-day enrollment pre-release, will be examined for 90-day enrollment pre-release:

Hypothesis 1: Pre-release enrollment will improve access to medical care for recently incarcerated members.

- *Example research question #1:* How many previously incarcerated individuals enroll in Medicaid through the Pre-Release Enrollment program over time?
- *Example research question #2:* How many previously incarcerated individuals enrolled in Medicaid through the Pre-Release Enrollment program access primary care services within one year of release?

Example measures	Data Source(s)
Number of previously incarcerated individuals enrolling in Medicaid	Medicaid population grid, Ecosystem RIDOC data
Number of previously incarcerated individuals accessing primary care services	Medicaid population grid, Medicaid claims, Ecosystem RIDOC data

Hypothesis 2: Pre-release enrollment will improve health outcomes for recently incarcerated members.

- *Example research question #1:* What are the trends in utilization (as measured by primary care and preventative services, mental health (MH) and SUD/OUD services, inpatient hospitalization and rehospitalization, ED visits) for Medicaid members enrolled through the Pre-Release Enrollment program?

Example measures	Data Source(s)
Primary care & preventative services	Medicaid claims, Ecosystem RIDOC data
MH & SUD/OUD services	Medicaid claims, Ecosystem RIDOC data
Inpatient hospitalization, rehospitalization	Medicaid claims, Ecosystem RIDOC data
ED visits and potentially avoidable ED visits	Medicaid claims, Ecosystem RIDOC data

In addition, EOHHS proposes to add the following hypothesis and example measure for this 90-day pre-release request:

Hypothesis 3: Pre-release supports will promote continuity of medication treatment for individuals receiving medications.

- *Example research question #1:* What are the trends in utilization (as measured by pharmacy claims) for Medicaid members enrolled through the Pre-Release Enrollment program?

Example measures	**Data Source(s)**
Pharmacy services	Medicaid claims; Ecosystem RIDOC data

Nutrition Services

Evaluation Approach: We will use descriptive statistics to characterize participation in both the Healthy Food Prescriptions and Medically Tailored Meals programs, including number of participants served, participant demographics (e.g., age, sex, race, ethnicity), and socioeconomic characteristics (measured using zip-code level data). To assess the effects of the programs, we propose interrupted time-series analyses comparing outcomes for members receiving services before and after service use, using repeated observations (quarterly or

annual, as data allows) in both time periods. If sample sizes allow, we will assess outcomes for each program separately. One limitation of this design is that members receiving services need to have been enrolled in Medicaid prior to their engagement in the program. We will plan to conduct a one-group posttest-only analysis If most members receiving these services are newly enrolled in Medicaid.

Given our current understanding of the Nutrition Services programs and the available data, we do not anticipate being able to construct a comparison group because it will not be possible to identify members with food insecurity who are not enrolled in the program. However, the evaluator will assess the feasibility of constructing a comparison group before deciding on the final design.

Hypothesis 1: The Nutrition Services program will improve healthcare utilization for participants.

- *Example research question #1:* What are the trends over time in utilization (primary care/preventative services, inpatient hospitalization, ED visits) for members using Nutrition Services? Do trends differ by race or ethnicity?

Hypothesis 2: The Nutrition Services programs will decrease Medicaid spending for participants.

- *Example research question #1:* What are the trends over time in spending (total Medicaid, inpatient, ED, outpatient) for members using Nutrition services? Does this differ by race or ethnicity?

Example measures	Data Source(s)
Total Medicaid spending	Medicaid claims
Medicaid spending for inpatient visits	Medicaid claims
Medicaid spending for ED visits	Medicaid claims
Medicaid spending for outpatient visits	Medicaid claims

CM Pilot Program

Evaluation Approach: We will use descriptive statistics to characterize participation in the program, including number of participants served, participant demographics (e.g., age, sex, race, ethnicity), and socioeconomic characteristics (measured using zip-code level data). We propose to conduct an interrupted time-series analysis for evaluation of the CM program, comparing outcomes for members before and after they started receiving services from the program. Because this program that is offered to all medically qualified individuals, there will be no available comparison group during the posttest period (even if some qualified individuals decline the program, an evaluator working with Medicaid data will have no way to track those individuals over time for a potential comparison).

Hypothesis 1: CM will improve access to mental health and SUD services for participating members.

- *Example research question #1:* What are rates of AOD initiation and treatment among participating members?

- *Example research question #2:* What are rates of mental health and SUD/OUD service utilization among participating members?

Example measures	Data Source(s)
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Medicaid claims
MH & SUD/OUD services	Medicaid claims

Hypothesis 2: CM will improve physical health care utilization for participating members.

- *Example research question #1:* What are the trends in utilization (as measured by primary care and preventative services, inpatient hospitalization and rehospitalization, ED visits) for Medicaid members participating in the CM program?

Example measures	Data Source(s)
Primary care & preventative services	Medicaid claims
Inpatient hospitalization, rehospitalization	Medicaid claims
ED visits and potentially avoidable ED visits	Medicaid claims

Hypothesis 3: CM will decrease rates of substance use among participating members.

- *Example research question #1:* What are the trends in abstinence from substance use for Medicaid members participating in the CM program?

Example measures	Data Source(s)
Abstinence from substance use	Program data

5.2 Oversight, Monitoring, and Reporting

The same oversight and monitoring described in the Extension request will continue to occur for the new elements being added or otherwise revised through this Addendum. This will include quarterly and annual Waiver Monitoring and Budget Neutrality reporting as well as Interim and Summative Evaluation Reports.

Section VI: Budget Neutrality Impact

Rhode Island has updated the budget neutrality analysis developed for the December 2022 Extension to account for the new or updated requests contained in this Addendum, specifically for Nutrition Services, Pre-Release Supports for Incarcerated Individuals and Contingency Management.

As a Health-Related Social Need initiative, the Nutrition Services proposed in this Addendum aligns with the CMS parameters for hypothetical treatment. Therefore, like the Home Stabilization Transitional Supports requested in the Extension, the updated budget neutrality

analysis treats Nutrition services as hypothetical and combines Home Stabilization and Nutrition Services into a single Health-Related Social Needs hypothetical expense. Rhode Island's budget neutrality analysis assumes that the number of households receiving Nutrition Services will be approximately 11,000 in the first year and 22,000; 28,800; and 30,000 in each subsequent year, respectively. This represents a range from 6% to 15% of the state's Medicaid households. On a per-household basis, this analysis assumes a monthly Healthy Food Prescription cost of $100 and a monthly medically tailored meal cost of $350.

Consistent with CMS guidance, the Addendum treats Pre-Release Supports for Incarcerated Individuals as hypothetical expenses. Rhode Island updated the budget neutrality reports to account for 90 days of pre-release coverage. In the budget neutrality analysis and consistent with the discussion above regarding eligibility/enrollment, Rhode Island assumes that approximately 2,000 individuals per year will receive 90 days of pre-release Medicaid and approximately 6,400 per year will receive 30 days of coverage while awaiting trial.

The updated budget neutrality reports include Contingency Management only in the "With Waiver" analysis. The state estimates that approximately 575 individuals will receive the CM service in the first year and that approximately 1,150 will receive the service each year thereafter, following the initial ramp-up period.

Detailed budget neutrality reports are provided in *Appendix A*.

Section VII: Public Notice & Comment Process

7.1 Overview of Compliance with Public Notice Process

In accordance with STC 15 and 59 Fed. Reg. 49249 (Sept. 27, 1994), EOHHS provided the public and other interested parties the opportunity to review and provide input on the demonstration Addendum through a formal thirty-day public notice and comment process, which ran from March 15, 2024 to April 15, 2024. During this time, the state also held two dedicated public hearings.

Public Notice

The state verifies that public notice of the Addendum application was published on March 15, 2024 to the state's Administrative Record and on a dedicated webpage on the agency's website. The abbreviated public notice was available in Spanish and Portuguese as well as English.

EOHHS utilized an electronic mailing list, comprised of over 525 interested individuals and organizations, to notify the public of the Addendum, hearings, and opportunity to comment on the Addendum draft. The message included a web address link to the Addendum on the state's updated waiver website, the location where hard copies of the Addendum were available for public review, information regarding the public comment period and how to comment, as well as details regarding the public hearings.

A copy of the formal public notice is attached as *Appendix B* and a copy of the abbreviated public notice is attached as *Appendix C*. Both documents are also available for viewing on the state's website: Waiver Extension | Executive Office of Health and Human Services (ri.gov).

Public Hearing

EOHHS conducted two public hearings during the thirty-day notice and comment period in geographically diverse areas of the state. The hearings were available for interested parties to attend either in person or virtually via Zoom platform. The state confirms the two hearings were held on the following dates and locations, as scheduled and publicized in the formal notice:

Public Hearing #1	**Public Hearing #2**
April 4, 2024 5:00-7:00 p.m. Eastern Newport Public Library 300 Spring Street Newport, RI 02840 Also available for virtual participation: Zoom link: https://us02web.zoom.us/j/85755366505?pwd=d1RValJiNUdPT0N6WktoaUNPMmdFdz09 Zoom Dial-In: 888-788-0099 • Meeting ID: 857 5536 6505 • Passcode: 900653	April 11, 2024 1:00-3:00 p.m. Eastern 3 West Road Virks Building 1st Floor Training Room Cranston, RI 02920 Also available for virtual participation: Zoom link: https://us02web.zoom.us/j/83258100849?pwd=bW5wRllvTDZRRHlqdzhhRDJqcGtQUT09 Zoom Dial-In: 888-788-0099 • Meeting ID: 832 5810 0849 • Passcode: 288364

Tribal Notice

Rhode Island has one federally recognized tribe in the state, the Narragansett Indian Tribe. EOHHS sent notice of the Addendum to the representative of the federally recognized tribe in accordance with 42 CFR § 431.408, with the option to schedule a separate tribal consultation to discuss the Addendum. The state provided the full public notice documentation to the tribal representatives, including a link to the Addendum, the location where hard copies are available, information regarding the public comment period and how to comment, and details regarding the public hearings. No formal comments were received, and a tribal consultation was not requested. A copy of the formal correspondence sent to the Narragansett Indian Tribe soliciting input on the extension request can be found in *Appendix D*.

7.2 Summary of Public Comments & State Responses

In total, EOHHS received comments from 14 unique individuals from the public and other interested parties during the public comment period, including 11 written comments and 3 verbal-only testimonies provided during public hearings (in addition, 6 individuals shared both verbal and written testimony/comment). Several commenters provided comments addressing several aspects of the waiver. EOHHS identified each unique item of feedback within each commenter's submission and thoughtfully analyzed and considered each item individually.

All verbal and written comments, along with the state's responses, are summarized below by relevant topic areas. Please note, because many comments responded to multiple components of the waiver, the "total comments" captured below reflects the number of unique points received for each topic, rather than total number of individual commenters.

7.2.1 Comments re: Nutrition Services

EOHHS received a total of 10 comments related to the proposed addition of Nutrition Services, all of which expressed support for Medicaid coverage of nutrition services and many of which recommended specific revisions and/or identified areas where it would be valuable for the state to develop more detailed implementation plans. In most instances, the more detailed operational topics will be addressed in a future implementation protocol, which EOHHS will develop in collaboration with stakeholders in the event that the Rhode Island legislature authorizes state spending to implement all or a portion of the proposed Nutrition Services.

Scope of and Eligibility for the Medically Tailored Meals Service:

Several commenters emphasized that many people would likely benefit from home-delivered, therapeutic meals but not meet the eligibility criteria for or necessarily need Medically Tailored Meals (MTM). EOHHS agrees that non-MTM home-delivered meals are also extremely valuable to many people. Individuals enrolled in LTSS, who meet the high/highest level of care, can access home-delivered meals as an HCBS benefit. Individuals enrolled in managed care may be able to access non-MTM home-delivered meals as an "in-lieu of service," which EOHHS will continue to encourage. In the context of this waiver, EOHHS believes that it is most appropriate to focus limited resources on the population that will benefit from MTM specifically.

One commenter suggested that the MTM eligibility criterion that a beneficiary be unable to shop and cook is likely too restrictive. EOHHS agrees and revised the proposal to include those unable to shop or cook. One commenter recommended that liver disease be added to the list of conditions that can confer eligibility for MTM; EOHHS agrees that liver disease is a diet-sensitive condition and revised the proposal to include liver disease as a condition that can make a person eligible for MTM or Healthy Food Prescriptions. Another commenter recommended that Alzheimer's Disease or Other Related Disorders be included as a condition conferring eligibility. EOHHS believes that individuals with Alzheimer's or a Related Disorder, in the absence of a diet-sensitive chronic disease, will primarily be benefitted by the LTSS home-delivered meal benefit and assistance from personal care attendants to support the Activities of Daily Living involved in meal preparation and eating, and for this reason EOHHS has not added Alzheimer's or a Related Disorder as an eligible condition.

One commenter recommended that EOHHS ensure access to MTM in both managed care and fee-for-service delivery systems. EOHHS is committed to ensuring access to all eligible beneficiaries regardless of whether they are enrolled in managed care. Whether nutrition services are delivered in managed care is a determination to be made as part of future implementation planning.

One commenter noted that Medical Nutrition Therapy may be needed to effectively transition a person from MTM when they are stabilized and no longer meet program criteria. EOHHS agrees that this may be useful and will explore opportunities to develop this additional service in the future, depending on budget and authority constraints.

Role of the Registered/Licensed Dietician:

Several commenters raised questions and made recommendations related to the role of a Registered/Licensed Dietician in the provision of MTM. These included comments noting that there are likely to be workforce challenges in ensuring access to Registered/Licensed Dieticians and encouraging engagement with the Rhode Island Department of Health to evaluate the existing workforce capacity; a recommendation that only Licensed Dieticians be considered

qualified providers of these MTM-related services; questioning whether an evaluation and nutrition care plan by a Registered/Licensed Dietician is necessary for all potential MTM beneficiaries; and recommending that Registered/Licensed Dieticians be included within the MTM agency rather than as a stand-alone provider/service. One commenter also recommended that evaluations be conducted in person, rather than virtually.

EOHHS appreciates that workforce challenges may arise with Registered/Licensed Dieticians. If the nutrition service is authorized by the state legislature, EOHHS will work to develop an implementation protocol to minimize the burden associated with this challenge and engage with RIDOH and stakeholders to evaluate provider network capacity.

EOHHS agrees that under Rhode Island Department of Health regulations, only Licensed Dieticians may practice dietetics in the state, and therefore has revised the proposal to specify "Licensed Dieticians." Licensed Dieticians will conduct evaluations, create nutrition care plans, and conduct reassessments.

MTM requires a nutrition care plan developed by a Licensed Dietician to qualify as MTM, because medically tailored meals are specifically designed for the member based on their condition(s)/diagnoses and other factors; they are not standard or based solely on one specific diagnosis. While there may be individuals for whom a nutrition care plan is not needed, these are expected to be individuals who do not require MTM and for whom, as discussed above, a therapeutic home-delivered meal is likely the more appropriate service.

EOHHS anticipates that Licensed Dieticians will be embedded within the agencies delivering MTM rather than delivering services as stand-alone providers. EOHHS will work with stakeholders to finalize policies related to this issue as part of the future implementation protocol.

If state budget authority is granted, EOHHS will collaborate with stakeholders on an implementation protocol that will identify whether, and under what circumstances, the evaluation by a Licensed Dietician can be conducted virtually rather than in person.

MTM Reassessment:

Several commenters questioned whether reassessment is needed every 3 months for all MTM beneficiaries and raised concerns that this would potentially be burdensome for the individuals and increase pressure on the limited workforce. EOHHS agrees that individual needs for reassessment likely vary. For this reason, while the default will remain every 3 months, EOHHS is revising the request to allow the prescribing provider to identify if a patient only needs reassessment at 6-month intervals. Because MTM is not designed to be a long-term benefit, a 12-month reassessment cadence for the service is not feasible. One commenter recommended more frequent follow up sessions based on the recommendation of the American Society for Parenteral and Enteral Nutrition. While some individuals may need more frequent follow-up sessions, this recommendation was made in the context of infants and children, whose conditions are likely to change particularly frequently, and EOHHS believed it is not appropriate to require more frequent reassessments for all beneficiaries.

Commenters requested more information on the purpose of the reassessments. The goal of the reassessment is to ensure the continued existence of medical necessity for MTM and to re-evaluate clinical/dietary needs. The scope of the reassessment and any performance standards/measures will be developed as part of any future implementation protocol.

MTM Guidelines:

Several commenters suggested additional guidelines that could be used in addition to the Food is Medicine Coalition guidelines for medically tailored meals, such as the Dietary Guidelines for Americans 2020-2025, the Nutrition Care Manual, and Federal Food Service Guidelines. One commenter recommended that EOHHS require that MTM providers use only the Food Is Medicine Coalition guidelines. The draft waiver language had stated that MTM meals must be developed in accordance with "the Food Is Medicine Coalition guidelines or other appropriate guidelines." For clarity, EOHHS has added language stating that such other appropriate guidelines must be approved by EOHHS. EOHHS expects to work closely with experts and stakeholders in developing an implementation protocol that confirms the approved guidelines for MTM.

One commenter recommended that EOHHS review the Food Is Medicine Coalition MTM Intervention Accreditation Criterion and Requirements and consider requiring that providers be accredited under these standards. EOHHS will review these standards in the context of collaborative implementation protocol development.

Reimbursement for Nutrition Services:

Commenters noted that it would be important to cover the cost of the Licensed Dietician services and asked whether it would be included in the reimbursement paid to the MTM provider or billed separately. Commenters also generally noted that adequate reimbursement is important for MTM and must include both food and clinical service, regardless of the exact payment methodology. EOHHS agrees that it is necessary to provide reimbursement for both food and clinical (Licensed Dietician) services. If the nutrition service is authorized by the state legislature, EOHHS will work to develop specific payment methodologies, including whether evaluation and assessment will be bundled into a single rate with MTM meals or paid separately.

One commenter recommended that in addition to the cost of food, EOHHS ensure that the cost of food box production – packaging, distribution, administration, and coordination of pick-up or delivery – be accounted for in rates paid for food boxes. EOHHS understands the importance of accounting for all necessary costs for nutrition service delivery. If the nutrition service is authorized by the state legislature, EOHHS will work to develop specific payment methodologies to ensure that the service can be delivered as designed.

Prior Authorization for Nutrition Services:

Several commenters questioned the need for prior authorization for MTM and/or Healthy Food Prescriptions, while one commenter supported the use of prior authorization for MTM. EOHHS believes that because of the vital role of clinical factors in determining eligibility for these services, prior authorization is appropriate for both MTM and Healthy Food Prescriptions. One commenter emphasized the importance of ensuring an administratively straightforward process for accessing MTM, especially for older beneficiaries and others who may have challenges navigating the healthcare system. EOHHS agrees that this is vital, and will work with stakeholders in developing the implementation protocol with this as a priority.

Two commenters requested further information and made recommendations related to the "service provider" and "screening tool" referenced in the Healthy Food Prescription eligibility description. EOHHS notes that the role of the "service provider" and "screening tool" in that context was specific to determination that a beneficiary is experiencing food insecurity. EOHHS

anticipates that a broad scope of clinical and social service providers (including Community Health Workers, for example) will be able to identify food insecurity using a broad array of screening tools. EOHHS revised the prior authorization language to emphasize that the service provider who determines the presence of food insecurity may be separate from the provider that prepares and submits a prior authorization request/prescription that must also account for clinical factors. EOHHS will work with stakeholders to develop the prior authorization structure for Healthy Food Prescriptions with the goals of ensuring adherence to medical necessity criteria while minimizing administrative burden and ensuring straightforward access to services for eligible beneficiaries.

Other Nutrition Service Eligibility Topics:

One commenter asked whether it would be possible, if an individual met criteria for both Healthy Food Prescriptions and MTM, to receive both services. EOHHS anticipates that an individual would only receive one service or the other, but it is possible that within one household, one family member could get MTM while another qualifies for a Healthy Food Prescription.

One commenter recommended the use of a standardized eligibility screening tool for MTM, and other commenters requested information on the screening tool or tools expected to be allowed for determining food insecurity for purposes of Healthy Food Prescription eligibility. EOHHS will work with stakeholders to finalize program requirements related to screening tools for both MTM and Healthy Food Prescriptions.

One commenter noted that individuals who are “rising” rather than “high” risk would likely benefit from services like Fruit and Vegetable Voucher Incentive programs. The eligibility criteria for Healthy Food Prescriptions does not identify a particular level of “risk” for poor health outcomes, but rather identifies specific characteristics for eligibility. This is likely to encompass both "high" and "rising" risk populations.

Scope of the Healthy Food Prescription Service:

Two commenters offered support for the state’s proposal to offer both nutrition vouchers and food boxes, depending on beneficiary preference. EOHHS appreciates this support.

Several commenters raised questions and made recommendations regarding the amount/size of the Healthy Food Prescription benefit in relation to household size. Commenters recommended that because families almost always share food, it is most appropriate to have a “dosage” of the “prescription” that is closely tied to household size. EOHHS understands the rationale behind these recommendations. If there are multiple eligible people in the household, the amount of a nutrition voucher/size of a healthy food box would reflect that. In general, implementation will be driven by the scope of legislative authority and the associated budget. For that reason, EOHHS is not able to define this more specifically. If given state budget authority, EOHHS will develop an implementation protocol with the support of stakeholder engagement. In particular, EOHHS will aim, within budget and federal authority constraints, to adjust for household size when the basis for eligibility is that a family includes children under age 6.

Several commenters emphasized the importance of including fruits and vegetables in the Healthy Food Prescription service, including specifically the existing Rhode Island Fruit and Vegetable Voucher Incentive Programs, and asked whether fruit and vegetable prescriptions would be accounted for under general groceries, therapeutic groceries, or in their own category.

Commenters also recommended specifying that vouchers would be able to be used to buy food at farmers markets, farm stands, and other local food vending locations, and recommended that food boxes contain locally harvested food to the extent possible. One commenter requested information on whether general retail or food pantries would be used to source groceries for the healthy food boxes. A commenter also recommended that all food boxes be culturally responsive, rather than requiring individuals to potentially need to choose between therapeutic and culturally responsive groceries.

EOHHS agrees that fruits and vegetables will be essential components of Healthy Food Prescriptions and revised the proposal language to specify that prescription produce would be a component of both general and therapeutic groceries. EOHHS expects that the existing Fruit and Vegetable Voucher Incentive Programs will be able to participate in the network for the nutrition voucher service, with operational details to be developed in the future implementation protocol. EOHHS anticipates that vouchers will be able to be used at farmers markets and other local food vending locations, however the details to operationalize this will be addressed in future implementation protocol development. EOHHS anticipates that retail and local produce – rather than food pantries – will be the sources for food box groceries, although again, operational details will be developed in the implementation protocol in collaboration with stakeholders if state budget authority is granted. EOHHS agrees that people should be able to access food boxes that are both therapeutic as well as culturally responsive, and revised the proposal language to reflect this.

Commenters noted that because fresh produce does not tend to remain fresh for multiple weeks at a time, the frequency of food box availability should be more often than monthly, even if the total amount of food is the same as initially contemplated. EOHHS agrees that this may be a challenge, and revised the language to remove the language specifying frequency of food box provision. Operational details needed to ensure availability of fresh produce while minimize the overhead cost of food box production and delivery will be developed in the implementation protocol.

<u>Other Implementation-Related Comments</u>:

One commenter asked who is responsible for meeting the provisions of the nutrition care plan outside of two meals per day. The proposal states that MTM meal delivery services will differ based on the severity of need, and estimates an average of two meals per day. If an individual is assessed to need two MTM meals per day, EOHHS anticipates that the scope of the nutrition care plan will focus on those two meals, while if the person is assessed to need three meals, it would include all three meals, which would then be included in the MTM benefit for that individual.

One commenter asked whether there are existing Rhode Island based providers ready to offer the nutrition services benefits when and if state budget authority is granted. EOHHS is under the impression that there are multiple providers who will be able to implement both Healthy Food Prescriptions and MTM. Other commenters recommended leveraging Community Health Workers to support Nutrition Services, including to proactively identify and respond to the range of interconnected health-related social needs that impact beneficiaries. EOHHS expects that CHWs are likely to provide services related to screening and Nutrition Services pursuant to the state's existing state plan benefit for CHW services. Another commenter raised the importance of connecting beneficiaries to non-Medicaid nutrition services (SNAP, WIC, free/reduced school meals), and EOHHS notes that CHWs are likely to be able to assist with this work under existing

authority as well. EOHHS will work with stakeholders to identity and operationalize any opportunities to further incorporate CHWs into this work.

One commenter noted that it would be helpful to isolate the impact of nutrition services from other variables in the state's evaluation of the service. EOHHS agrees and expects to develop an Evaluation Design Plan that aims to identify the distinct impact of Demonstration programs.

Infrastructure Funding:

Commenters expressed appreciation for the inclusion of infrastructure funding in the state's budget neutrality tables and identified key areas where this funding would be most useful, especially for strengthening capacity of nutrition social service organizations by partnering with community-based organization and managed care organizations and supporting service providers' investments in infrastructure and technology, as well as for technical assistance for these organizations. One commenter also recommended leveraging infrastructure funds to generally support development of a robust MTM network and to do an environmental scan for availability of Licensed Dieticians, especially in underserviced areas. EOHHS appreciates feedback on the potential uses of infrastructure money and will work with stakeholders on the best plan to spend any funds allocated by the state.

7.2.2 Comments re: Pre-Release Supports

EOHHS received one comment regarding Pre-Release Supports, which stated support for the proposed coverage expansion from 30 to 90 days pre-release.

EOHHS appreciates the support for the proposed expansion to 90 days.

7.2.3 Comments re: Contingency Management

EOHHS received one comment regarding Contingency Management, which stated support for the program's inclusion and a request that if successful, the pilot be implemented as a covered benefit for Medicaid beneficiaries.

EOHHS appreciates the support for Contingency Management and clarifies that under this Demonstration, the pilot would become a covered benefit for Medicaid beneficiaries, albeit without a guarantee of long-term availability beyond the duration of this Demonstration period.

7.2.4 Comments re: Home and Community-Based Services Technical Changes

EOHHS received 6 comments regarding proposed edits to the state's Home and Community-Based Services (HCBS) as described in Attachment B.

Removal of Services Lacking State Budget Authority for Implementation:

Several commenters described the potential value of certain services, currently listed in Attachment B, which the state proposes to remove from Attachment B because they have not been implemented (for the Preventive population and/or for both the Preventive and the High/ Highest level of care populations). With respect to Preventive services specifically, commenters focused on Respite, Peer Support Services, and Home-Delivered Meals. With respect to both Preventive and High/ Highest level of care populations, commenters focused on Chore Services and Training and Counseling for Unpaid Caregivers.

EOHHS agrees that each of these has potential to be a valuable service, in some cases both for individuals who meet a High/Highest level of care and those who do not.

EOHHS does not currently have budget authority to implement Respite, Peer Support Services, or Home-Delivered Meals for individuals not meeting the High or Highest level of care. Chore Services and Training and Counseling for Unpaid Caregivers are not authorized to be available to any beneficiaries, regardless of level of care. In the absence of new spending authority from the state legislature, Respite, Peer Support Services, and Home-Delivered Meals cannot be implemented beyond participants who meet a High or Highest level of care, while Chore Services and Training and Counseling for Unpaid Caregivers cannot be implemented for any beneficiaries, regardless of level of care. The state is not permitted to keep un-implemented services listed as HCBS waiver services, and therefore must remove them. In the event that EOHHS received the necessary budget authority, EOHHS would amend the waiver and/or state plan as needed to implement them.

With respect to Home-Delivered Meals, EOHHS notes that the state anticipates that if Nutrition Services are authorized for implementation, some individuals who might be considered "preventive" will qualify for medically tailored meals. In addition, EOHHS notes that managed care organizations are able to offer home-delivered meals as an in-lieu of service, and EOHHS expects to work with MCOs to fully leverage this option in the future.

With respect to Peer Support Services, EOHHS agrees with commenters that the state plan Community Health Worker (CHW) benefit is not identical to the Peer Support Services and revised the proposal language to avoid this implication. EOHHS does encourage utilization of the CHW benefit in cases where it can meet a similar need, but appreciates that these are distinct services. EOHHS also notes for general clarification that the HCBS Peer Support service is not connected to, and is entirely distinct from, the Peer Recovery Specialist 1115 waiver service. EOHHS is not proposing any changes to the Peer Recovery Specialist service.

One commenter expressed that the draft waiver’s identification of several Preventive services as unnecessary for individuals not meeting the High or Highest level of care was likely incorrect because many people access Preventive services while they are going through the time-consuming process of seeking LTSS eligibility, and these individuals may ultimately be approved for LTSS and have a need for Respite or Community Transitions even before being approved for LTSS eligibility. EOHHS appreciates that some people may "need" LTSS services for a period of time before they are formally determined eligible for those services. The previous language regarding what the "preventive" population would "need" was working from the perspective that it is difficult to authorize services that assume a certain level of care when that level of care has not actually been established for a given person. However, EOHHS has revised the language around these services to account for this nuance. Specifically with respect to community transitions, EOHHS notes that this service is for people who are in an institutional level of care and are seeking to transition back to the community. EOHHS does anticipate that only people who meet a High or Highest level of care would have been residing in an institution and be in a position to use this particular service.

One commenter asked about the response from legislators when confronted about the Preventive services not authorized by the legislature. EOHHS proposed implementing Home-Delivered Meals for the Preventive population in the SFY24 budget, but it was not included due to cost/budget constraints.

Other Service Changes:

One commenter observed that the “Preventive” population currently has difficulty accessing PERS and asked what the plan was to ensure access. Following review of this comment, EOHHS identified that while PERS may be federally permitted as a state plan DME service, the state has not previously authorized it outside of the LTSS context (and only for people who meet a High or Highest level of care). In the absence of state budget authority to expand access to PERS beyond the High/ Highest level of care, EOHHS intends to work with managed care organizations to offer PERS as an in-lieu of service. EOHHS anticipates that this will increase access for people who do not meet the High or Highest level of care. In light of this, EOHHS has revised the proposal language to retain PERS as an HCBS for the High/ Highest level of care.

Change in Authority from HCBS to the State Plan for Personal care and Homemaker Services:

Several commenters expressed concern about the potential for any changes to the mechanism by which individuals not enrolled in managed care are determined eligible for Personal Care and Homemaker Services, emphasizing that the current approach is efficient and effective in achieving access to services for beneficiaries for whom these services are medically necessary. Commenters also encouraged EOHHS to ensure that medical necessity determinations for state plan benefits follow the current methodology used for fee-for-service (FFS) beneficiaries to ensure the current rapid response will be maintained.

EOHHS agrees that the current process for FFS beneficiaries to access Personal Care and Homemaker services is efficient and effective. It is in large part to ensure that the state can maintain this process - rather than imposing a more complex level of care determination - that the state seeks to use state plan authority for these services. EOHHS does not intend to alter the current process for FFS beneficiaries (or for managed care beneficiaries). To respond to a specific commenter question, EOHHS does not intend to change the process by which the Office of Medical Review may refer FFS beneficiaries denied LTSS to an assessment of whether they need Personal Care and Homemaker services. EOHHS agrees that a person who is denied LTSS may still meet state plan medical necessity standards for Personal Care and/or Homemaker services and will use the same mechanism to determine that medical necessity as is in place now. In other words, this has been and will remain a medical necessity determination, implemented by a vendor contracted by the state to make these determinations, upon referral by the Department of Human Services or EOHHS.

One commenter asked whether there are beneficiaries who are only able to access services today because they meet a Preventive level of care. In the managed care context, MCOs evaluate whether a person needs Personal Care and Homemaker services on the basis of medical necessity and do not specify in that analysis whether the person would meet a "Preventive" level of care. For managed care enrollees then, there are no people only getting these services based on meeting a Preventive level of care. For FFS beneficiaries, there is currently a medical necessity determination as well. While this determination is currently framed as identifying FFS beneficiaries who meet a "Preventive" level of care, it remains a specific type of medical necessity determination, which will be maintained going forward as it is today.

One commenter asked how the removal of the Preventive HCBS segment of the waiver would impact services delivered by the “OHA and other co-pay programs.” Rhode Island has authority to provide HCBS-like services to older people (Budget Population 10) and disabled people (Budget Population 15) who do not otherwise qualify for Medicaid and who are at risk for needing long-term care if they do not receive those services. These populations are not otherwise eligible for Medicaid under the state plan or waiver and do not receive full Medicaid

benefits. The Preventive HCBS service list in Attachment B is not the source of authority for service delivery to Budget Populations 10 or 15, and its elimination will not affect these populations.

One commenter asked about eligibility requirements to establish disability for services authorized under the state plan, in particular for Durable Medical Equipment (DME) and also asked about the state response to the "2016 Lewin Report recommendations to improve LTSS by removing proof of Federal/SS determination of disability for proof of disability." There is no requirement that a beneficiary establish that they are disabled in order to access Personal Care/Homemaker services or DME under the state plan. Therefore, there are no such eligibility requirements. Currently, LTSS eligibility does not require that a person be determined disabled by either the state or the Social Security Administration. Rather, LTSS eligibility depends on meeting a High or Highest Level of Care. Similarly, DME is available based on medical necessity and does not require a Level of Care or a determination of disability.

One commenter asked why, if Personal Care and Homemaker services are authorized under the state plan, the state would ever have created the Preventive level of care in the first place. EOHHS believes this is a result of changes in authority and program structure over time. In particular, 2016 changes to federal definitions of the home health benefit expanded the scope of what can be covered in that category and made it possible to offer those services on the basis of medical necessity rather than a specific LTSS level of care.

One commenter requested information on the webpages where information could be found for the public on how to access "LTSS Preventive Services that are currently authorized under the 1115 waiver for older adults and individuals with disabilities, or those who meet Preventive Levels of Care." As noted above, the authority for Budget Populations 10 and 15 (1115 authority for certain HCBS-like services to be provided for older adults and individuals with disabilities who are not otherwise eligible for Medicaid) is entirely distinct from Preventive HCBS. The EOHHS website has a link to the OHA At Home Cost Care program (Budget Population 10) at this page, the relevant link is the fourth from the bottom of the page: https://eohhs.ri.gov/consumer/older-adults. Information related to the similar program for adults with disabilities (Budget Population 15) is available here: Services For The Blind And Visually Impaired (SBVI) | RI DHS Office of Rehabilitation Services, Technology, Equipment & Home Mod | OSCIL,and https://www.oscil.org/pca-program. The "HCBS Brochure" at https://myoptions.ri.gov/fact-sheets-and-brochures briefly discusses the Preventive service.

Preventive Services, In General:

One commenter expressed that Preventive Services were intended to provide the state with more flexibility in providing an array of community support, and raised concerns that the state plan might be more restrictive in eligibility criteria, provider networks, and payment methodology. EOHHS is confident that changing the authority for Personal Care and Homemaker services to the state plan will not diminish the state's ability to offer these services. As compared to current "Preventive" authority in the waiver, using state plan authority does not necessitate any new restrictions in terms of eligibility criteria, provider networks, or payment methodology, and EOHHS does not anticipate changes in any of these. From a service perspective, because all HCBS listed in the waiver, including Preventive HCBS, are required to actually be made available, the state is not permitted to have unimplemented federal authorities as a way to maintain flexibility to offer more services in case they are authorized by the state at a future date.

One commenter noted that Rhode Island has made progress with LTSS data reporting and expressed confusion as to why the state would have difficulty with data on the Preventive population. This commenter as well as a second commenter requested data on service utilization under the waiver relative to state plan services and other, non-Medicaid services.

EOHHS has worked closely with its sister agencies and CMS and greatly improved reporting on HCBS quality measures as required by CMS for HCBS populations. The challenge that arose for EOHHS was that the Preventive population cannot be accurately identified under the current methodologies because it is not a distinct program in the way that “core” HCBS programs are. Rather, individuals are enrolled in managed care or fee-for-service Medicaid and then get access to Personal Care and/or Homemaker services if they are medically necessary – which could be for a “preventive” reason but could also be for other reasons. The managed care population receives personal care and homemaker services on a medical necessity basis that does not involve a formal level of care determination. It would have been extremely challenging to separate - either in existing data or through future processes - whether a person receives Personal Care and/or Homemaker services in order to prevent them from later needing LTSS, or whether the person receives the services for other medical necessity reasons. It is not feasible to share data on utilization because of this very problem. For the state to accomplish this separate data tracking, beneficiaries would, at the very least, need to undergo a more complex, formal level of care determination. EOHHS did not and does not wish to impose more administrative burdens on beneficiaries in order to access the services they are entitled to under the state plan.

One commenter asked how Perry Sullivan rebalancing funds have been used to fund Preventive services. In general, the state has used Perry Sullivan rebalancing funds to increase rates for Personal Care and Homemaker services under both state plan and waiver authorities.

One commenter suggested that by retaining the Preventive services, the state would be able to help provide flexibility of behavioral health service delivery to individuals transitioning back to the community, especially considering the forthcoming Certified Community Behavioral Health Clinic service. The commenter also recommended that the state develop an interdepartmental state initiative focused on the mental health of older adults. EOHHS agrees that there may be individuals who both receive Personal Care and/or Homemaker services and receive services through a Certified Community Behavioral Health Clinic. EOHHS does not anticipate any other respect in which "Preventive” services and CCBHC would be connected. EOHHS appreciates the recommendation to develop an interdepartmental state initiative related to older adults' behavioral health needs and will consider future opportunities to do so.

One commenter recommended that EOHHS undertake a community engagement initiative for future planning related to HCBS. EOHHS agrees that ongoing community engagement will be vital for future planning and looks forward to doing so.

7.3 Summary of Revisions

Above, EOHHS summarized and responded to all of the public comments received concerning the Demonstration extension request Addendum during the 30-day public comment period. EOHHS considered each comment and has decided to make several changes to the Demonstration extension request Addendum based on the feedback provided. In this section, EOHHS has explained and summarized the changes that have been made in response to public comment as well as the impetus for making those changes. A table summarizing these changes

can be found below, while the following section also provides a more detailed description of each change and its impact on the overall request, as applicable.

Waiver Section	Description of Revisions to Waiver Draft
2.1.1 Nutrition Services	• Added statement that Healthy Food Prescriptions include, but are not limited to, prescription fruit and vegetable programs. • Added statement that general and therapeutic groceries should also be selected to be culturally responsive. • Removed “once per month” language regarding frequency of Healthy Food Prescriptions. • Added liver disease as a chronic disease that could confer eligibility for Healthy Food Prescriptions and Medically Tailored Meals. • Added statement that prior authorization will include information on the criteria of food insecurity as determined by a service provider or screening tool as well as information on the additional eligibility criteria for Healthy Food Prescriptions. • Removed “Registered Dietician” from description of the initial evaluation for MTM to ensure clarity that only Licensed Dieticians are qualified to conduct that service, and added language to clarify that Licensed Dieticians will conduct the regular reassessments as well. • Added clarification that nutritional guidelines for MTM would be either the Food Is Medicine Coalition guidelines or other appropriate guidelines approved by EOHHS. • Changed the requirement for regular reassessment to allow the prescribing clinician to identify in the prior authorization request that an individual requires less frequent reassessments, at a minimum of every six months. • Revised the criteria for MTM eligibility to include individuals who lack the capacity or shop and/or cook for themselves – rather than lacking the ability to do both.
2.3.1 Preventive HCBS	• Revised introductory language to more clearly state that the Preventive services listed in the waiver that are <u>not</u> in the state plan have <u>not</u> been implemented, and that therefore these services cannot continue to be listed as HCBS. • Revised language characterizing the non-implemented Preventive services to remove framing of Peer Supports as similar to the state plan Community Health Worker benefit and Chore Services as similar to state plan Homemaker services. • Revised language characterizing non-implemented Preventive services to remove framing of any service as inherently unnecessary for the Preventive, non-LTSS population. • Removed reference to PERS as a covered state plan service and added it to the list of services that are being removed due to not having been implemented for the non-LTSS population. • Revised description of the Assistive Technology benefit to clarify that it will continue to be available to the same extent as is currently the case, specifically through the state plan Durable Medical Equipment benefit. • Added a statement noting that Home-Delivered Meals will remain available for the LTSS population and also that non-LTSS managed

	care beneficiaries may be able to access Home-Delivered Meals as an in-lieu of service.
2.3.2 Other Technical Changes to Attachment B	• Removed PERS from the list of services to be removed from Attachment B (i.e., PERS will remain in Attachment B for individuals meeting the High or Highest level of care).

Revisions to Section 2.1.1: Nutrition Services:

- Added statement that Healthy Food Prescriptions include, but are not limited to, prescription fruit and vegetable programs. EOHHS intended to include these programs within Healthy Food Prescriptions, and in consideration of comments requesting that they be included, EOHHS determined that explicitly stating their inclusion would maximize clarity.
- Added statement that therapeutic and general groceries should also be selected to be culturally responsive. EOHHS agreed with commenters that a person in need of therapeutic groceries should also be able to have those groceries be culturally responsive, rather than having to choose between these needs. EOHHS determined that it would be less confusing for providers and beneficiaries to require general and therapeutic groceries to be culturally responsive rather than making culturally responsive meals their own category.
- Removed “once per month” language regarding frequency of Healthy Food Prescriptions. EOHHS understood from commenters that greater frequency of food delivery may be needed for fresh produce and aims to develop more detailed operational requirements as part of the implementation protocol.
- Added liver disease as a chronic disease that could confer eligibility for Healthy Food Prescriptions and Medically Tailored Meals. EOHHS agrees with the comment that liver disease is a diet-sensitive condition for which nutrition services could be highly valuable.
- Added statement that prior authorization will include information on the criteria of food insecurity as determined by a service provider or screening tool as well as information on the additional criteria for Healthy Food Prescriptions. EOHHS added this statement to improve clarity regarding the role of service providers and screening tools, which is focused on identifying food insecurity rather than making prior authorization requests.
- Removed “Registered Dietician” from description of the initial evaluation for MTM so that only Licensed Dieticians are qualified to conduct that service, and added language to clarify that Licensed Dieticians will conduct the regular reassessments as well. EOHHS made these changes because only Licensed Dieticians are qualified to provide dietetics in Rhode Island.
- Added clarification that nutritional guidelines for MTM would be either the Food Is Medicine Coalition guidelines or other appropriate guidelines approved by EOHHS. EOHHS understands from comments that there are several sets of guidelines that may be appropriate for MTM, and added the “approved by EOHHS” language so that it would be clearer that the state would approve guidelines at a future time, as part of the implementation protocol.
- Changed the requirement for regular reassessment to allow the prescribing clinician to identify in the prior authorization request that an individual requires less frequent reassessments, at a minimum of every six months. EOHHS learned from commenters that in some cases, reassessment does not need to be as frequent as every three months and that for those beneficiaries this requirement could be burdensome. Therefore, EOHHS requests

approval to allow referring clinicians to identify cases where less frequent reassessment is clinically appropriate.
- Revised the criteria for MTM eligibility to include individuals who lack the capacity or shop and/or cook for themselves – rather than lacking the ability to do both. EOHHS received comment that being unable to both shop and cook could be unnecessarily restrictive and agreed with this point.

Revisions to Section 2.3.1: Preventive HCBS:

- Revised introductory language to more clearly state that the Preventive services listed in the waiver that are not in the state plan have not been implemented, and that therefore these services cannot continue to be listed as HCBS. EOHHS appreciated from comments that the distinction between implemented and non-implemented services was confusing and aimed to improve the discussion of this distinction.
- Revised language characterizing the non-implemented Preventive services to remove framing of Peer Supports as similar to the state plan Community Health Worker benefit and Chore Services as similar to state plan Homemaker services. EOHHS appreciated commenters emphasis that both Peer Support and Chore services had the potential to provide particular value that would not be met by existing state plan services. In addition, EOHHS aimed to be clearer that the reason for removal of the services from Attachment B is that they were not implemented and not authorized by the state budget for implementation, rather than that EOHHS had made a judgement that they would not potentially have value for beneficiaries.
- Revised language characterizing non-implemented Preventive services to remove framing of any service as inherently unnecessary for the Preventive, non-LTSS population. EOHHS appreciated commenters' emphasis that non-LTSS beneficiaries could benefit from certain services like Respite, especially those individuals in the process of applying for LTSS. EOHHS aimed to be clearer that the reason for removal of the services from Attachment B is that they were not implemented and not authorized by the state for implementation, regardless of whether they would potentially have value for beneficiaries.
- Removed reference to PERS as a covered state plan service and added it to the list of services that are being removed due to not having been implemented for the non-LTSS population. Upon further review based on a public comment noting the difficulty of obtaining PERS for non-LTSS beneficiaries, EOHHS identified that PERS has not been implemented within the state plan DME benefit at this time and therefore revised the discussion of this service. EOHHS still lacks state budget authority to implement this service for non-LTSS beneficiaries, but intends to work with managed care organizations to make it more available as an in-lieu of service.
- Revised description of the Assistive Technology benefit to clarify that it will continue to be available to the same extent as is currently the case, specifically through the state plan Durable Medical Equipment benefit. EOHHS made this change solely to increase clarity that the relevant state plan benefit of medical supplies, equipment and appliances is also known as Durable Medical Equipment, as this term may be more familiar to many people.
- Added a statement noting that Home-Delivered Meals will remain available for the LTSS population and also that non-LTSS managed care beneficiaries may be able to access Home-Delivered Meals as an in-lieu of service. Because several commenters emphasized the importance of this benefit, EOHHS added this language to emphasize that LTSS beneficiaries would continue to have access to it – that it would not be removed from the LTSS HCBS service package – and to increase awareness that managed care organizations may offer it as an in-lieu of service today to non-LTSS beneficiaries.

Revisions to Section 2.3.2: Other Technical Changes to Attachment B

- Removed PERS from the list of services to be removed from Attachment B (i.e., PERS will remain in Attachment B for individuals meeting the High or Highest level of care). As discussed above, EOHHS identified that this service is not identical to an existing state plan service, and therefore it is appropriate for it to remain listed as an LTSS HCBS service.

Appendix A: Budget Neutrality Worksheets

	A	B	C	D	E	F	G
1	**5 YEARS OF HISTORIC DATA**						
2							
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**						
4							
5	**Pop 1. ABD no TPL**	**HY 1 (CY 2017)**	**HY 2 (CY 2018)**	**HY 3 (CY 2019)**	**HY 4 (CY 2020)**	**HY 5 (CY 2021)**	**5-YEARS**
6	**TOTAL EXPENDITURES**	$ 268,476,462	$ 283,334,689	$ 330,133,616	$ 304,925,667	$ 344,478,759	$ 1,531,349,192
7	**ELIGIBLE MEMBER MONTHS**	179,647	177,761	173,815	172,667	171,765	
8	**PMPM COST**	$ 1,494.47	$ 1,593.91	$ 1,899.34	$ 1,765.98	$ 2,005.52	
9	**TREND RATES**						**5-YEAR**
10				**ANNUAL CHANGE**			**AVERAGE**
11	TOTAL EXPENDITURE		5.53%	16.52%	-7.64%	12.97%	6.43%
12	ELIGIBLE MEMBER MONTHS		-1.05%	-2.22%	-0.66%	-0.52%	-1.12%
13	PMPM COST		6.65%	19.16%	-7.02%	13.56%	7.63%
14							
15	**Pop 2. ABD TPL**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
16	**TOTAL EXPENDITURES**	$ 269,885,976	$ 250,546,864	$ 219,410,648	$ 190,132,028	$ 216,926,304	$ 1,146,901,820
17	**ELIGIBLE MEMBER MONTHS**	287,270	297,535	288,025	290,451	303,876	
18	**PMPM COST**	$ 939.49	$ 842.08	$ 761.78	$ 654.61	$ 713.86	
19	**TREND RATES**						**5-YEAR**
20				**ANNUAL CHANGE**			**AVERAGE**
21	TOTAL EXPENDITURE		-7.17%	-12.43%	-13 34%	14.09%	-5.31%
22	ELIGIBLE MEMBER MONTHS		3.57%	-3.20%	0 84%	4.62%	1.41%
23	PMPM COST		-10.37%	-9.54%	-14 07%	9.05%	-6.64%
24							
25	**Pop 3. ABD LTSS**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
26	**TOTAL EXPENDITURES**	$ 724,033,942	$ 745,167,513	$ 820,733,227	$ 783,326,661	$ 803,607,144	$ 3,876,868,487
27	**ELIGIBLE MEMBER MONTHS**	176,684	177,507	178,549	173,328	166,371	
28	**PMPM COST**	$ 4,097.90	$ 4,197.96	$ 4,596.68	$ 4,519.33	$ 4,830.21	
29	**TREND RATES**						**5-YEAR**
30				**ANNUAL CHANGE**			**AVERAGE**
31	TOTAL EXPENDITURE		2.92%	10.14%	-4 56%	2.59%	2.64%
32	ELIGIBLE MEMBER MONTHS		0.47%	0.59%	-2 92%	-4.01%	-1.49%
33	PMPM COST		2.44%	9.50%	-1.68%	6.88%	4.20%
34							
35	**Pop 4. Rite Care**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
36	**TOTAL EXPENDITURES**	$ 515,019,502	$ 523,900,737	$ 584,755,268	$ 540,281,451	$ 661,604,382	$ 2,825,561,340
37	**ELIGIBLE MEMBER MONTHS**	2,069,454	2,021,958	1,937,553	1,934,573	2,074,006	
38	**PMPM COST**	$ 248.87	$ 259.11	$ 301.80	$ 279.28	$ 319.00	
39	**TREND RATES**						**5-YEAR**
40				**ANNUAL CHANGE**			**AVERAGE**
41	TOTAL EXPENDITURE		1.72%	11.62%	-7.61%	22.46%	6.46%
42	ELIGIBLE MEMBER MONTHS		-2.30%	-4.17%	-0.15%	7.21%	0.05%
43	PMPM COST		4.11%	16.48%	-7.46%	14.22%	6.40%
44							
45	**Pop 5. CSHCN**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
46	**TOTAL EXPENDITURES**	$ 170,107,095	$ 168,132,484	$ 167,369,332	$ 169,999,309	$ 182,811,295	$ 858,419,514
47	**ELIGIBLE MEMBER MONTHS**	147,208	147,761	143,051	145,585	147,024	
48	**PMPM COST**	$ 1,155.56	$ 1,137.87	$ 1,170.00	$ 1,167.70	$ 1,243.41	
49	**TREND RATES**						**5-YEAR**
50				**ANNUAL CHANGE**			**AVERAGE**
51	TOTAL EXPENDITURE		-1.16%	-0.45%	1 57%	7.54%	1.82%
52	ELIGIBLE MEMBER MONTHS		0.38%	-3.19%	1.77%	0.99%	-0.03%
53	PMPM COST		-1.53%	2.82%	-0 20%	6.48%	1.85%
54							
55	**Pop 6. Expansion**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
56	**TOTAL EXPENDITURES**	$ 479,099,781	$ 451,290,490	$ 475,460,073	$ 545,106,889	$ 765,644,669	$ 2,716,601,902
57	**ELIGIBLE MEMBER MONTHS**	962,548	936,990	897,870	985,547	1,193,095	
58	**PMPM COST**	$ 497.74	$ 481.64	$ 529.54	$ 553.10	$ 641.73	
59	**TREND RATES**						**5-YEAR**
60				**ANNUAL CHANGE**			**AVERAGE**
61	TOTAL EXPENDITURE		-5.80%	5.36%	14.65%	40.46%	12.43%
62	ELIGIBLE MEMBER MONTHS		-2.66%	-4.18%	9.76%	21.06%	5.51%
63	PMPM COST		-3.24%	9.95%	4.45%	16.02%	6.56%
64							
65	**Pop 7. Family Planning**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
66	**TOTAL EXPENDITURES**	$ 53,490	$ 116,238	$ 359,192	$ 406,225	$ 245,689	$ 1,180,834
67	**ELIGIBLE MEMBER MONTHS**	12,183	13,138	17,700	21,044	18,163	
68	**PMPM COST**	$ 4.39	$ 8.85	$ 20.29	$ 19.30	$ 13.53	
69	**TREND RATES**						**5-YEAR**
70				**ANNUAL CHANGE**			**AVERAGE**
71	TOTAL EXPENDITURE		117.31%	209.01%	13 09%	-39.52%	46.40%
72	ELIGIBLE MEMBER MONTHS		7.84%	34.72%	18 89%	-13.69%	10.50%
73	PMPM COST		101.51%	129.37%	-4 88%	-29.93%	32.49%
74							
75	**Other Populations & CNOMS**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
76	**TOTAL EXPENDITURES**	$ 9,176,311	$ 9,399,975	$ 9,839,671	$ 8,397,342	$ 8,152,058	$ 44,965,356
77	**ELIGIBLE MEMBER MONTHS**	53,953	55,061	55,361	52,925	52,394	
78	**PMPM COST**	$ 170.08	$ 170.72	$ 177.74	$ 158.66	$ 155.59	
79	**TREND RATES**						**5-YEAR**
80				**ANNUAL CHANGE**			**AVERAGE**
81	TOTAL EXPENDITURE		2.44%	4.68%	-14.66%	-2.92%	-2.92%
82	ELIGIBLE MEMBER MONTHS		2.05%	0.54%	-4.40%	-1.00%	-0.73%
83	PMPM COST		0.38%	4.11%	-10.73%	-1.94%	-2.20%
84							
85	**New Pop: Pre-Release Supports**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
86	**TOTAL EXPENDITURES**						$ -
87	**ELIGIBLE MEMBER MONTHS**						
88	**PMPM COST**						
89	**TREND RATES**						**5-YEAR**
90				**ANNUAL CHANGE**			**AVERAGE**
91	TOTAL EXPENDITURE						
92	ELIGIBLE MEMBER MONTHS						
93	PMPM COST						

	A	B	C	D	E	F	G	H	I	J	K
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**										
2											
3											
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**BASE YEAR**	**TREND**	**DEMONSTRATION YEARS (DY)**					**TOTAL**
5	**GROUP**	**RATE 1**	**OF AGING**	**DY 15 (CY 2023)**	**RATE 2**	**DY 16 (CY 2024)**	**DY 17 (CY 2025)**	**DY 18 (CY 2026)**	**DY 19 (CY 2027)**	**DY 20 (CY 2028)**	**WOW**
6											
7	**Pop 1. ABD no TPL**										
8	**Pop Type:**	**Medicaid**									
9	Eligible Member Months	0.00%	24	171,765	1.2%	173,826	175,912	178,023	180,159	182,321	
10	PMPM Cost	7.63%	24	$ 2,323.24	7.1%	$ 2,488.89	$ 2,666.35	$ 2,856.46	$ 3,060.13	$ 3,278.32	
11	Total Expenditure					$ 432,634,241	$ 469,043,212	$ 508,515,691	$ 551,310,927	$ 597,707,327	$ 2,559,211,398
12											
13	**Pop 2. ABD TPL**										
14	**Pop Type:**	**Medicaid**									
15	Eligible Member Months	-1.31%	24	295,967	1.3%	299,903	303,892	307,933	312,029	316,179	
16	PMPM Cost	6.70%	24	$ 812.73	6.0%	$ 861.49	$ 913.18	$ 967.97	$ 1,026.05	$ 1,087.61	
17	Total Expenditure					$ 258,363,397	$ 277,507,791	$ 298,070,317	$ 320,157,293	$ 343,879,359	$ 1,497,978,157
18											
19	**Pop 3. ABD LTSS**										
20	**Pop Type:**	**Medicaid**									
21	Eligible Member Months	2.47%	24	174,691	1.6%	177,486	180,326	183,211	186,143	189,121	
22	PMPM Cost	6.70%	24	$ 5,499.14	9.2%	$ 6,007.26	$ 6,562.33	$ 7,168.69	$ 7,831.08	$ 8,554.67	
23	Total Expenditure					$ 1,066,206,289	$ 1,183,359,181	$ 1,313,384,924	$ 1,457,698,125	$ 1,617,867,324	$ 6,638,515,842
24											
25	**Pop 4. Rite Care**										
26	**Pop Type:**	**Medicaid**									
27	Eligible Member Months	-0.75%	24	2,043,013	1.1%	2,065,281	2,087,793	2,110,550	2,133,555	2,156,811	
28	PMPM Cost	8.11%	24	$ 372.84	6.6%	$ 397.60	$ 424.00	$ 452.15	$ 482.17	$ 514.19	
29	Total Expenditure					$ 821,155,887	$ 885,224,221	$ 954,285,145	$ 1,028,736,172	$ 1,109,010,473	$ 4,798,411,899
30											
31	**Pop 5. CSHCN**										
32	**Pop Type:**	**Medicaid**									
33	Eligible Member Months	-0.55%	24	145,411	1.0%	146,923	148,451	149,995	151,555	153,131	
34	PMPM Cost	6.70%	24	$ 1,415.61	6.0%	$ 1,500.55	$ 1,590.58	$ 1,686.01	$ 1,787.17	$ 1,894.40	
35	Total Expenditure					$ 220,465,992	$ 236,123,924	$ 252,893,669	$ 270,855,098	$ 290,092,280	$ 1,270,430,963
36											
37	**Pop 6. Expansion**										
38	**Pop Type:**	**Expansion**									
39	Eligible Member Months	-3.62%	24	1,108,278	-0.1%	1,107,392	1,106,506	1,105,621	1,104,736	1,103,852	
40	PMPM Cost	9.01%	24	$ 762.58	6.7%	$ 813.67	$ 868.19	$ 926.36	$ 988.43	$ 1,054.65	
41	Total Expenditure					$ 901,051,467	$ 960,657,326	$ 1,024,202,754	$ 1,091,954,365	$ 1,164,177,906	$ 5,142,043,818
42											
43	**Pop 7. Family Planning**										
44	**Pop Type:**	**Medicaid**									
45	Eligible Member Months	-0.64%	24	17,931	1.5%	18,195	18,462	18,734	19,009	19,289	
46	PMPM Cost	32.49%	24	$ 23.74	4.8%	$ 24.88	$ 26.07	$ 27.32	$ 28.63	$ 30.00	
47	Total Expenditure					$ 452,688	$ 481,313	$ 511,805	$ 544,230	$ 578,656	$ 2,568,692
48											
49	**Other Populations & CNOMS**										
50	**Pop Type:**	**Medicaid**									
51	Eligible Member Months	0.00%	24	52,394	1.2%	53,023	53,659	54,303	54,955	55,614	
52	PMPM Cost	6.70%	24	$ 177.14	4.8%	$ 185.64	$ 194.55	$ 203.89	$ 213.68	$ 223.94	
53	Total Expenditure					$ 9,843,139	$ 10,439,359	$ 11,071,820	$ 11,742,687	$ 12,454,199	$ 55,551,204
54											
55	**New Pop: Pre-Release Supports**										
56	**Pop Type:**	**Hypothetical**									
57	Eligible Member Months	0.00%		-	1.2%	10,825	10,955	11,086	11,219	11,354	
58	PMPM Cost	6.70%		$ -	4.8%	$ 583.86	$ 611.88	$ 641.25	$ 672.03	$ 704.29	
59	Total Expenditure					$ 6,320,250	$ 6,703,084	$ 7,109,128	$ 7,539,770	$ 7,996,528	$ 35,668,760
60											
61	**New Pop: Pre-Release Supports - Infrastructure**										
62	**Pop Type:**	**Hypothetical**									
63				$ -		$ 2,085,683	$ 2,212,018	$ 1,066,369	$ 1,130,966	$ 1,199,479	$ 7,694,514
64											
65	**New Benefit: Health Related Social Needs (HRSN)**										
66	**Pop Type:**	**Hypothetical**									
67	Total Expenditure					$ 30,273,035	$ 61,265,606	$ 90,204,349	$ 132,839,105	$ 137,606,404	$ 452,188,499
68											
69	**New Benefit: Health Related Social Needs (HRSN) - Infrastructure**										
70	**Pop Type:**	**Hypothetical**									
71						$ 3,027,303	$ 6,126,561	$ 4,510,217	$ 6,641,955	$ 6,880,320	$ 27,186,357
72											
73											
74											
75											
76											
77	**NOTES**										
78	For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.										

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 15 (CY 2023)	TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (CY 2024)	DY 17 (CY 2025)	DY 18 (CY 2026)	DY 19 (CY 2027)	DY 20 (CY 2028)	TOTAL WW
Pop 1. ABD no TPL								
Pop Type:	**Medicaid**							
Eligible Member Months	171,765	1.2%	173,826	175,912	178,023	180,159	182,321	
PMPM Cost	$ 2,323.24	6.1%	$ 2,464.96	$ 2,615.32	$ 2,774.85	$ 2,944.12	$ 3,123.71	
Total Expenditure			$ 428,670,972	$ 460,458,041	$ 494,377,696	$ 530,799,957	$ 569,906,803	$ 2,484,213,469
Pop 2. ABD TPL								
Pop Type:	**Medicaid**							
Eligible Member Months	295,967	1.3%	299,903	303,892	307,933	312,029	316,179	
PMPM Cost	$ 812.73	6.1%	$ 862.31	$ 914.91	$ 970.72	$ 1,029.93	$ 1,092.76	
Total Expenditure			$ 258,808,562	$ 278,429,395	$ 299,310,405	$ 321,758,653	$ 345,895,802	$ 1,504,202,817
Pop 3. ABD LTSS								
Pop Type:	**Medicaid**							
Eligible Member Months	174,691	1.6%	177,486	180,326	183,211	186,143	189,121	
PMPM Cost	5,499	6.1%	$ 5,834.59	$ 6,190.50	$ 6,568.12	$ 6,968.78	$ 7,393.88	
Total Expenditure			$ 1,035,559,731	$ 1,116,308,538	$ 1,203,353,721	$ 1,297,187,302	$ 1,398,337,615	$ 6,050,746,908
Pop 4. Rite Care								
Pop Type:	**Medicaid**							
Eligible Member Months	2,043,013	1.1%	2,065,281	2,087,793	2,110,550	2,133,555	2,156,811	
PMPM Cost	$ 372.84	6.1%	$ 395.58	$ 419.71	$ 445.31	$ 472.47	$ 501.29	
Total Expenditure			$ 816,984,019	$ 876,267,589	$ 939,848,984	$ 1,008,040,689	$ 1,081,187,616	$ 4,722,328,897
Pop 5. CSHCN								
Pop Type:	**Medicaid**							
Eligible Member Months	145,411	1.0%	146,923	148,451	149,995	151,555	153,131	
PMPM Cost	$ 1,415.61	6.1%	$ 1,501.96	$ 1,593.58	$ 1,690.79	$ 1,793.93	$ 1,903.36	
Total Expenditure			$ 220,673,154	$ 236,569,278	$ 253,610,647	$ 271,879,612	$ 291,464,338	$ 1,274,197,030
Pop 6. Expansion								
Pop Type:	**Medicaid**							
Eligible Member Months	1,108,278	-0.1%	1,107,392	1,106,506	1,105,621	1,104,736	1,103,852	
PMPM Cost	$ 762.58	6.1%	$ 809.10	$ 858.46	$ 910.83	$ 966.39	$ 1,025.34	
Total Expenditure			$ 895,990,687	$ 949,891,024	$ 1,007,032,465	$ 1,067,605,980	$ 1,131,823,993	$ 5,052,344,149
Pop 7. Family Planning								
Pop Type:	**Medicaid**							
Eligible Member Months	17,931	1.5%	18,195	18,462	18,734	19,009	19,289	
PMPM Cost	$ 23.74	6.1%	$ 25.19	$ 26.73	$ 28.36	$ 30.09	$ 31.93	
Total Expenditure			$ 458,328	$ 493,498	$ 531,288	$ 571,984	$ 615,883	$ 2,670,980
Other Populations & CNOMS								
Pop Type:	**Medicaid**							
Eligible Member Months	52,394	1.2%	53,023	53,659	54,303	54,955	55,614	
PMPM Cost	$ 177.14	6.1%	$ 187.95	$ 199.41	$ 211.57	$ 224.48	$ 238.17	
Total Expenditure			$ 9,965,622	$ 10,700,141	$ 11,488,866	$ 12,336,196	$ 13,245,586	$ 57,736,411
New Pop: Pre-Release Supports								
Pop Type:	**Hypothetical**							
Eligible Member Months	-	1.2%	10,825	10,955	11,086	11,219	11,354	
PMPM Cost	$ -	4.8%	$ 583.86	$ 611.88	$ 641.25	$ 672.03	$ 704.29	
Total Expenditure			$ 6,320,250	$ 6,703,084	$ 7,109,128	$ 7,539,770	$ 7,996,528	$ 35,668,760
New Pop: Pre-Release Supports - Infrastructure								
Pop Type:	**Hypothetical**							
			$ 2,085,683	$ 2,212,018	$ 1,066,369	$ 1,130,966	$ 1,199,479	$ 7,694,514
New Benefit: Health Related Social Needs (HRSN)								
Pop Type:	**Hypothetical**							
Total Expenditure			$ 30,273,035	$ 61,265,606	$ 90,204,349	$ 132,839,105	$ 137,606,404	$ 452,188,499
New Benefit: Health Related Social Needs (HRSN) - Infrastructure								
Pop Type:	**Hypothetical**							
			$ 3,027,303	$ 6,126,561	$ 4,510,217	$ 6,641,955	$ 6,880,320	$ 27,186,357

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS	20__	20__	20__	20__	20__
State DSH Allotment (Federal share)					
State DSH Claim Amount (Federal share)					
DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)						
State DSH Claim Amount (Federal share)						
DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
State DSH Claim Amount (Federal share)						
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS		DY 01	DY 02	DY 03	DY 04	DY 05
DSH Diversion to Leading FFY (total computable)						
FMAP for Leading FFY						
DSH Diversion to Trailing FFY (total computable)						
FMAP for Trailing FFY						
Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 16 (CY 2024)	DY 17 (CY 2025)	DY 18 (CY 2026)	DY 19 (CY 2027)	DY 20 (CY 2028)	
Medicaid Populations						
Pop 1. ABD no TPL	$ 432,634,241	$ 469,043,212	$ 508,515,691	$ 551,310,927	$ 597,707,327	$ 2,559,211,398
Pop 2. ABD TPL	$ 258,363,397	$ 277,507,791	$ 298,070,317	$ 320,157,293	$ 343,879,359	$ 1,497,978,157
Pop 3. ABD LTSS	$ 1,066,206,289	$ 1,183,359,181	$ 1,313,384,924	$ 1,457,698,125	$ 1,617,867,324	$ 6,638,515,842
Pop 4. Rite Care	$ 821,155,887	$ 885,224,221	$ 954,285,145	$ 1,028,736,172	$ 1,109,010,473	$ 4,798,411,899
Pop 5. CSHCN	$ 220,465,992	$ 236,123,924	$ 252,893,669	$ 270,855,098	$ 290,092,280	$ 1,270,430,963
Pop 6. Expansion	$ 901,051,467	$ 960,657,326	$ 1,024,202,754	$ 1,091,954,365	$ 1,164,177,906	$ 5,142,043,818
Pop 7. Family Planning	$ 452,688	$ 481,313	$ 511,805	$ 544,230	$ 578,656	$ 2,568,692
DSH Allotment Diverted	$ -	$ -	$ -	$ -	$ -	$ -
Other WOW Categories						
Other Populations & CNOMS	$ 9,843,139	$ 10,439,359	$ 11,071,820	$ 11,742,687	$ 12,454,199	$ 55,551,204
Pre-Release Supports	$ 6,320,250	$ 6,703,084	$ 7,109,128	$ 7,539,770	$ 7,996,528	$ 35,668,760
Pre-release Supports Infrastructure	$ 2,085,683	$ 2,212,018	$ 1,066,369	$ 1,130,966	$ 1,199,479	$ 7,694,514
HRSN	$ 30,273,035	$ 61,265,606	$ 90,204,349	$ 132,839,105	$ 137,606,404	$ 452,188,499
HRSN Infrastructure	$ 3,027,303	$ 6,126,561	$ 4,510,217	$ 6,641,955	$ 6,880,320	$ 27,186,357
TOTAL	$ 3,751,879,372	$ 4,099,143,594	$ 4,465,826,188	$ 4,881,150,693	$ 5,289,450,255	$ 22,487,450,102

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 16 (CY 2024)	DY 17 (CY 2025)	DY 18 (CY 2026)	DY 19 (CY 2027)	DY 20 (CY 2028)	
Medicaid Populations						
Pop 1. ABD no TPL	$ 428,670,972	$ 460,458,041	$ 494,377,696	$ 530,799,957	$ 569,906,803	$ 2,484,213,469
Pop 2. ABD TPL	$ 258,808,562	$ 278,429,395	$ 299,310,405	$ 321,758,653	$ 345,895,802	$ 1,504,202,817
Pop 3. ABD LTSS	$ 1,035,559,731	$ 1,116,308,538	$ 1,203,353,721	$ 1,297,187,302	$ 1,398,337,615	$ 6,050,746,908
Pop 4. Rite Care	$ 816,984,019	$ 876,267,589	$ 939,848,984	$ 1,008,040,689	$ 1,081,187,616	$ 4,722,328,897
Pop 5. CSHCN	$ 220,673,154	$ 236,569,278	$ 253,610,647	$ 271,879,612	$ 291,464,338	$ 1,274,197,030
Pop 7. Family Planning	$ 458,328	$ 493,498	$ 531,288	$ 571,984	$ 615,883	$ 2,670,980
Expansion Populations						
Pop 6. Expansion	$ 895,990,687	$ 949,891,024	$ 1,007,032,465	$ 1,067,605,980	$ 1,131,823,993	$ 5,052,344,149
Excess Spending From Hypotheticals						$ -
Other WW Categories						
Other Populations & CNOMS	$ 9,965,622	$ 10,700,141	$ 11,488,866	$ 12,336,196	$ 13,245,586	$ 57,736,411
Pre-release Supports	$ 6,320,250	$ 6,703,084	$ 7,109,128	$ 7,539,770	$ 7,996,528	$ 35,668,760
Pre-release Supports Infrastructure	$ 2,085,683	$ 2,212,018	$ 1,066,369	$ 1,130,966	$ 1,199,479	$ 7,694,514
HRSN	$ 30,273,035	$ 61,265,606	$ 90,204,349	$ 132,839,105	$ 137,606,404	$ 452,188,499
HRSN Infrastructure	$ 3,027,303	$ 6,126,561	$ 4,510,217	$ 6,641,955	$ 6,880,320	$ 27,186,357
TOTAL	$ 3,708,817,346	$ 4,005,424,772	$ 4,312,444,135	$ 4,658,332,169	$ 4,986,160,367	$ 21,671,178,790
VARIANCE	$ 43,062,026	$ 93,718,822	$ 153,382,053	$ 222,818,524	$ 303,289,887	$ 816,271,312

Appendix B: Formal Public Notice

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

PUBLIC NOTICE OF PROPOSED RHODE ISLAND COMPREHENSIVE 1115 DEMONSTRATION WAIVER EXTENSION REQUEST ADDENDUM

In accordance with 42 CFR 431.408 and Rhode Island General Laws Chapter 42-35, notice is hereby given that the Rhode Island Executive Office of Health and Human Services (EOHHS) proposes to submit to the Centers for Medicare and Medicaid Services (CMS) a request to add to its request to extend the Rhode Island Comprehensive 1115 Demonstration Waiver (11-W-00242/1). This notice provides details about the waiver extension request addendum and serves to formally open the thirty (30) day public comment period, which begins on March 15, 2024 and will conclude on April 15, 2024.

During the public comment period, the public is invited to provide written comments to EOHHS via US postal service or electronic mail, as well as make comments verbally during two public hearings. Specifically, notice is hereby given in accordance with the provisions of Chapter 42-35 of the Rhode Island General Laws, as amended, that the Secretary will hold two public hearings, as detailed below, at which times and places all interested persons therein will be heard on the above-mentioned matter. Public hearings will be held on the following dates, times, and locations:

Public Hearing #1	**Public Hearing #2**
April 4, 2024 5:00-7:00 p.m. Eastern Newport Public Library 300 Spring Street Newport, RI 02840 Also available for virtual participation: Zoom link: https://us02web.zoom.us/j/85755366505?pwd=d1RValJiNUdPT0N6WktoaUNPMmdFdz09 Zoom Dial-In: 888-788-0099 • Meeting ID: 857 5536 6505 • Passcode: 900653	April 11, 2024 1:00-3:00 p.m. Eastern 3 West Road Virks Building 1st Floor Training Room Cranston, RI 02920 Also available for virtual participation: Zoom link: https://us02web.zoom.us/j/83258100849?pwd=bW5wRllvTDZRRHlqdzhhRDJqcGtQUT09 Zoom Dial-In: 888-788-0099 • Meeting ID: 832 5810 0849 • Passcode: 288364

The proposed extension request addendum is accessible for public review on the EOHHS website at https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2024-03/RI%201115%20Waiver%20Extension%20Request%20Addendum_For%20Public%20Comment.pdf. The extension request addendum and other related documentation are accessible for public review on the EOHHS website at https://eohhs.ri.gov/reference-center/medicaid-state-plan-and-1115-waiver/waiver-extension. In addition, the draft documents are also available in hard copy, located at the Security Desk on the 1st floor of the Virks Building at 3 West Road, Cranston, RI 02920.

Interested persons should submit comments to EOHHS on the proposed extension request addendum on or before April 15, 2024. Comments can be submitted via email to OHHS.RIMedicaidWaiver@ohhs.ri.gov or by mail to Amy Katzen, Executive Office of Health and Human Services, 3 West Road, Cranston, RI 02920.

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Program Description

EOHHS is submitting an extension request addendum for the Rhode Island 1115 waiver (hereinafter "the Demonstration"), which has been in place since 2009 and authorizes Rhode Island's entire Medicaid program. In December 2022, Rhode Island submitted a Demonstration extension request. The extension request contained a variety of program enhancement requests, such as a home stabilization service expansion, Recuperative Care Pilot, strategies for driving support to Health Equity Zones, authority for pre-release supports for incarcerated individuals, HCBS enhancements, and the expansion of managed dental benefits to adults. The extension request also sought a number of technical revisions to components of the waiver concerning benefits, eligibility, and programs that were no longer active. The State received a Completeness Letter for the extension request from CMS on January 5th, 2023. On September 12, 2023, the State submitted an Amendment to allow the provision of Home and Community-Based Personal Care services in acute hospital settings, in order to improve outcomes for Medicaid HCBS waiver participants receiving care in acute hospital settings. The State received a Completeness Letter for this Amendment request from CMS on September 25th, 2023.

The State now requests an addendum to the pending Demonstration extension request to continue to pursue the extension's goals and objectives related to Health Equity, Behavioral Health, Long-Term Services & Supports, and Maintenance and Expansion on Our Record of Excellence. Specifically, the

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

State seeks Health Equity Program Enhancements, Behavioral Health Enhancements and Technical Updates, and Home and Community-Based Services (HCBS) Technical Changes, as described below.

Goals and Objectives

The State identified the following goals for the extension:

- Goal 1: Health Equity. Improve health equity through strong community-clinical linkages that support beneficiaries in addressing social determinants of health, including ensuring access to stable housing.
- Goal 2: Behavioral Health. Continue to ensure expanded access to high-quality integrated behavioral healthcare that is focused on prevention, intervention, and treatment.
- Goal 3: Long-Term Services & Supports (LTSS). Continue progress toward rebalancing LTSS toward home and community-based services (HCBS).
- Goal 4: Maintain and Expand on Our Record of Excellence. Streamline administration of the Demonstration to strengthen current services and processes, while supporting continued progress towards our state's goals of improving healthcare quality and outcomes for Medicaid beneficiaries.

This extension addendum is aligned with and builds on these goals by requesting program enhancements to support health equity and behavioral health and technical changes to HCBS authorities.

Eligibility, Benefits, Cost Sharing, and Delivery Systems,

This extension addendum would make one change to eligibility: to provide Medicaid coverage for incarcerated individuals for 90 days before their release from incarceration. The state estimates that this will lead to an additional 12,400 member months per year for the pre-release coverage population.

This extension addendum would have the following impact on covered benefits:

- Increase access to new services, including Nutrition Services and Contingency Management
- Not decrease access to any existing services, because:
    - All implemented "Preventive HCBS" services are and will remain available either through the state plan or other waiver authorities; and
    - The Attachment B "Core" and "Home and Community-Based Therapeutic Services" the state requests to remove from the waiver either are already available through the state plan, will be made available through the state plan through upcoming state plan Amendments, or have not been implemented.

Rhode Island is not proposing any changes to Medicaid cost sharing or delivery systems through this addendum to the extension request.

Summary of Proposed Changes

In the time since Rhode Island developed the extension submitted in December 2022, CMS has shared new opportunities and guidance related to health equity efforts. This includes details on Health-Related Social Need services such as Nutrition Services and significant guidance on the scope of the Reentry 1115 Demonstration Opportunity. Based on this guidance, the state requests the following health equity program enhancements:

- Nutrition Services: In recognition of the growing body of evidence of the impact of food and health outcomes, Rhode Island seeks to join CMS and other state Medicaid programs in testing food as medicine initiatives to achieve positive health outcomes for our beneficiaries and disrupt the cycle of food and nutrition health inequities. Specifically, Rhode Island requests authority to provide Healthy Food Prescriptions and Medically Tailored Meals.

- Pre-Release Supports for Incarcerated Individuals: In its extension request, Rhode Island sought to obtain authority to provide an array of pre-release services to incarcerated individuals. Rhode Island seeks to update the state's request for pre-release supports to include 90 days of pre-release coverage rather than 30 days. Rhode Island is also leveraging this extension request addendum to provide additional details related to pre-release supports.

Rhode Island also requests authority to enhance behavioral health services:

- Contingency Management: This service is a behavioral intervention to treat substance-use disorder, including opioid and stimulant use disorders.

- Family and Youth Support Partners: Update the provider qualifications to clarify the support partner roles.

Finally, Rhode Island proposes to continue the state's efforts to ensure accuracy and clarity in Attachment B, which lists the state's Home and Community Based Services (HCBS). These proposed changes will not alter or reduce the services currently delivered to Medicaid beneficiaries, but rather are intended to accurately describe the source of authority for the services currently delivered and to remove references to services that have not been implemented.

These changes include:

- Preventive HCBS: Elimination of the Preventive HCBS benefit category under the waiver. Each Preventive service that is currently delivered is already authorized through the state plan and will continue to be available on the same terms as currently available.

- Core HCBS:
    - Moving Home Stabilization from Attachment B because it is authorized elsewhere in the waiver and is not an HCBS.
    - Modification to Consultative Clinical and Therapeutic Services to include assistance to paid support staff, to align with the definition in the HCBS Technical Guide.

  - Replacement of Day Treatment and Supports with the specific, separate services the state has implemented, including Individual, Family, and Group Therapy; Occupational, Physical, and Speech-Language Therapy; and Behavior Analysis and Management.
  - Removal from the waiver those services that 1) are duplicative of state plan services, 2) have never been implemented, or 3) are no longer implemented as distinct services.

- Home and Community-Based Therapeutic Services (HBTS):
  - Moving Coordinated Specialty Care from Attachment B because it is not an HCBS.
  - Removal from the waiver of all other HBTS services because they are duplicative of state plan and other waiver services.

Rhode Island Executive Office of Health and Human Services

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Enrollment and Expenditures

Enrollment and expenditure data for the extension request addendum can be found in the table below.

	Base Year	Waiver Period				
	DY 15 (2023)	DY 16 (2024)	DY 17 (2025)	DY 18 (2026)	DY 19 (2027)	DY 20 (2028)
PMPM						
Pop 1. ABD no TPL	$2,323	$2,466	$2,618	$2,777	$2,946	$3,126
Pop 2. ABD TPL	$813	$863	$916	$972	$1,031	$1,094
Pop 3. ABD LTSS	$5,499	$5,835	$6,191	$6,568	$6,969	$7,394
Pop 4. Rite Care	$366	$396	$420	$445	$472	$501
Pop 5. CSHCN	$1,416	$1,502	$1,594	$1,691	$1,794	$1,903
Pop 6. Expansion	$749	$809	$858	$911	$966	$1,025
Pop 7. Family Planning	$24	$25	$27	$28	$30	$32
Pre-Release Supports		$777	$814	$737	$773	$810
Other Populations & CNOMS	$177	$188	$199	$212	$224	$238
Health Related Social Needs		$8	$17	$23	$34	$35
Enrollment - Member Months						
Pop 1. ABD no TPL	171,765	173,826	175,912	178,023	180,159	182,321
Pop 2. ABD TPL	295,967	299,903	303,892	307,933	312,029	316,179
Pop 3. ABD LTSS	174,691	177,486	180,326	183,211	186,143	189,121
Pop 4. Rite Care	2,043,013	2,065,281	2,087,793	2,110,550	2,133,555	2,156,811
Pop 5. CSHCN	145,411	146,923	148,451	149,995	151,555	153,131
Pop 6. Expansion	1,108,278	1,107,392	1,106,506	1,105,621	1,104,736	1,103,852
Pop 7. Family Planning	17,931	18,195	18,462	18,734	19,009	19,289
Pre-Release Supports		10,825	10,955	11,086	11,219	11,354
Other Populations & CNOMS	52,394	53,023	53,659	54,303	54,955	55,614
Total Expenditures						
Pop 1. ABD no TPL		$428,670,972	$460,458,041	$494,377,696	$530,799,957	$569,906,803
Pop 2. ABD TPL		$258,808,562	$278,429,395	$299,310,405	$321,758,653	$345,895,802
Pop 3. ABD LTSS		$1,035,559,731	$1,116,308,538	$1,203,353,721	$1,297,187,302	$1,398,337,615
Pop 4. Rite Care		$816,984,019	$876,267,589	$939,848,984	$1,008,040,689	$1,081,187,616
Pop 5. CSHCN		$220,673,154	$236,569,278	$253,610,647	$271,879,612	$291,464,338
Pop 6. Expansion		$895,990,687	$949,891,024	$1,007,032,465	$1,067,605,980	$1,131,823,993
Pop 7. Family Planning		$458,328	$493,498	$531,288	$571,984	$615,883
Pre-release Supports		$8,405,933	$8,915,102	$8,175,497	$8,670,736	$9,196,008
Other Populations & CNOMS		$9,965,622	$10,700,141	$11,488,866	$12,336,196	$13,245,586
Health Related Social Needs		$33,300,338	$67,392,166	$94,714,566	$139,481,061	$144,486,724
New Benefit: CM [1]		$817,074	$1,613,182	$1,592,587	$1,572,356	$1,552,481

Note 1. This reflects anticipated cost of Contingency Management, but it is included in existing MEGs.

Rhode Island Executive Office of Health and Human Services

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Hypotheses and Evaluation Parameters

Rhode Island will conduct an independent evaluation to measure and monitor the outcomes of the Demonstration. The State proposes to evaluate this Demonstration extension request addendum utilizing the following questions, hypotheses, and measures in addition to the hypotheses and evaluation parameters described in the extension submitted in December 2022.

90-Day Enrollment Pre-Release for Incarcerated Individuals

Hypotheses	Example Research Questions	Example Measures and Data Source
Pre-release enrollment will improve access to medical care for recently incarcerated members	How many previously incarcerated individuals enroll in Medicaid through the Pre-Release Enrollment program over time? How many previously incarcerated individuals enrolled in Medicaid through the Pre-Release Enrollment program access primary care services within one year of release?	Number of previously incarcerated individuals enrolling in Medicaid Number of previously incarcerated individuals accessing primary care services Data sources: Medicaid population grid, Ecosystem RIDOC data
Pre-release enrollment will improve health outcomes for recently incarcerated members	What are the trends in utilization (as measured by primary care and preventative services, mental health (MH) and SUD/OUD services, inpatient hospitalization and rehospitalization, ED visits) for Medicaid members enrolled through the Pre-Release Enrollment program?	Primary care & preventative services; MH & SUD/OUD services; Inpatient hospitalization, rehospitalization; ED visits and potentially avoidable ED visits Data sources: Medicaid claims, Ecosystem RIDOC data
Pre-release supports will promote continuity of medication treatment for individuals receiving medications.	What are the trends in utilization (as measured by pharmacy claims) for Medicaid members enrolled through the Pre-Release Enrollment program?	Pharmacy services Data sources: Medicaid claims, Ecosystem RIDOC data

Nutrition Support Services:

Hypotheses	Example Research Questions	Example Measures and Data Source
The Nutrition Support Services program will improve healthcare utilization for participants	What are the trends over time in utilization (primary care/preventative services, inpatient hospitalization, ED visits) for members using Nutrition Support Services? Do trends differ by race or ethnicity?	Inpatient hospitalization, rehospitalization; ED visits and potentially avoidable ED visits; Inpatient length of stay. Data source: Medicaid claims.
The Nutrition Support Services programs will decrease Medicaid spending for participants	What are the trends over time in spending (total Medicaid, inpatient, ED, outpatient) for members using Nutrition Support services? Does this differ by race or ethnicity?	Total Medicaid spending; Medicaid spending for inpatient visits; Medicaid spending for ED visits; Medicaid spending for outpatient visits Data source: Medicaid claims.

Contingency Management Pilot Program:

Hypotheses	Example Research Questions	Example Measures and Data Source
CM will improve access to mental health and SUD services for participating members	What are rates of AOD initiation and treatment among participating members? What are rates of mental health and SUD/OUD service utilization among participating members?	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET); MH & SUD/OUD services Data source: Medicaid claims
CM will improve physical health care utilization for participating members	What are the trends in utilization (as measured by primary care and preventative services, inpatient hospitalization and rehospitalization, ED visits) for Medicaid members participating in the CM program?	Primary care & preventative services; Inpatient hospitalization, rehospitalization; ED visits and potentially avoidable ED visits Data source: Medicaid claims
CM will decrease rates of substance use among participating members	What are the trends in abstinence from substance use for Medicaid members participating in the CM program?	Abstinence from substance use Data source: Program data

Rhode Island Executive Office of Health and Human Services

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Waiver and Expenditure Authorities

The State is requesting the following waiver and expenditure authorities to implement the new and enhanced programs and services under this Extension Request Addendum.

Authority Requested	Waiver Category	Statutory/Regulatory Citation
Waiver Authorities		
Health-Related Social Need Services	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)
Contingency Management Pilot	Benefits	Amount, Duration, and Scope Section 1902 (a)(10)(B)
Expenditure Authorities		
Provide Coverage for Incarcerated Individuals 90 Days Prior to Release	Eligibility	Expenditure Authority under 1115(a)(2) of the Act (CNOM)
Health-Related Social Need Services	Benefits	Expenditure Authority under 1115(a)(2) of the Act (CNOM)
Contingency Management Pilot	Benefits	Expenditure Authority under 1115(a)(2) of the Act (CNOM)

Appendix C: Abbreviated Public Notice

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

ABBREVIATED PUBLIC NOTICE OF PROPOSED RHODE ISLAND COMPREHENSIVE 1115 DEMONSTRATION WAIVER EXTENSION REQUEST ADDENDUM

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The state requests the following health equity program enhancements:

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    - Removal from the waiver of all other HBTS services because they are duplicative of state plan and other waiver services.

The proposed extension request addendum is accessible for public review on the EOHHS website at https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2024-03/RI%201115%20Waiver%20Extension%20Request%20Addendum_For%20Public%20Comment.pdf. The formal public notice is accessible for public review on the EOHHS website at https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2024-03/RI%201115%20Waiver%20Extension%20Addendum%20Formal%20Public%20Notice.pdf. These and other related documentation are accessible for public review on the EOHHS website at https://eohhs.ri.gov/reference-center/medicaid-state-plan-and-1115-waiver/waiver-extension. In addition, the draft documents are also available in hard copy, located at the Security Desk on the 1st floor of the Virks Building at 3 West Road, Cranston, RI 02920.

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

Public Hearings

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April 4, 2024 5:00-7:00 p.m. Eastern Newport Public Library 300 Spring Street Newport, RI 02840 Also available for virtual participation: Zoom link: https://us02web.zoom.us/j/85755366505?pwd=d1RValJiNUdPT0N6WktoaUNPMmdFdz09 Zoom Dial-In: 888-788-0099 • Meeting ID: 857 5536 6505 • Passcode: 900653	April 11, 2024 1:00-3:00 p.m. Eastern 3 West Road Virks Building 1st Floor Training Room Cranston, RI 02920 Also available for virtual participation: Zoom link: https://us02web.zoom.us/j/83258100849?pwd=bW5wRllvTDZRRHlqdzhhRDJqcGtQUT09 Zoom Dial-In: 888-788-0099 • Meeting ID: 832 5810 0849 • Passcode: 288364

Public Comments

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Non-Discrimination and Accommodations

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Appendix D: Tribal Notice

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

March 15, 2024

Autumn leaf Spears
Narragansett Indian Health Center
4533 South County Trail
Charlestown, RI 02913

Dear Director Spears,

In accordance with the requirements of our Tribal Consultation Policy, this is to notify you that the Rhode Island Executive Office of Health and Human Services (EOHHS) proposes to submit to the Centers for Medicare and Medicaid Services (CMS) a request to add to its request to extend the Rhode Island Comprehensive 1115 Demonstration Waiver (11-W-00242/1).

The Demonstration provides federal authority for EOHHS to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery system that improve care, increase efficiency, and reduce costs. Rhode Island's 1115 waiver (hereinafter "the Demonstration") has been in place since 2009. In December 2022, Rhode Island submitted an extension request for the Demonstration. The extension contained a variety of program enhancement requests and technical revisions. The State received a Completeness Letter for this extension request from CMS on January 5th, 2023. On September 12, 2023, the State submitted an Amendment to allow the provision of Home and Community-Based Personal Care services in acute hospital settings, in order to improve outcomes for Medicaid HCBS waiver participants receiving care in acute hospital settings. The State received a Completeness Letter for this Amendment request from CMS on September 25th, 2023.

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The state requests the following health equity program enhancements:

- Nutrition Services: Rhode Island requests authority to provide Healthy Food Prescriptions and Medically Tailored Meals.

- Pre-Release Supports for Incarcerated Individuals: In its extension request, Rhode Island sought to obtain authority to provide an array of pre-release services to incarcerated individuals. Rhode Island seeks to update the state's request for pre-release supports to include 90 days of pre-release coverage rather than 30 days. Rhode Island is also leveraging this extension request addendum to provide additional details related to pre-release supports.

Rhode Island also requests authority to enhance behavioral health services:

- Contingency Management: This service is a behavioral intervention to treat substance-use disorder, including opioid and stimulant use disorders.

- Family and Youth Support Partners: Update the provider qualifications to clarify the support partner roles.

Finally, Rhode Island proposes to continue the State's efforts to ensure accuracy and clarity in Attachment B, which lists the state's Home and Community Based Services (HCBS). These proposed changes will not alter or reduce the services currently delivered to Medicaid beneficiaries. They are intended to accurately describe the source of authority for the services currently delivered and to remove references to services that have not been implemented.

These changes include:

- Preventive HCBS: Elimination of the Preventive HCBS benefit category under the waiver. Each Preventive service that is currently delivered is already authorized through the state plan and will continue to be available on the same terms as currently available.

- Core HCBS:
    - Moving Home Stabilization from Attachment B because this service is already authorized elsewhere in the waiver and is not an HCBS.
    - Modification to Consultative Clinical and Therapeutic Services to include assistance to paid support staff, to align with the definition in the HCBS Technical Guide.
    - Replacement of Day Treatment and Supports with the specific, separate services the state has implemented, including Individual, Family, and Group Therapy; Occupational, Physical, and Speech-Language Therapy; and Behavior Analysis and Management.
    - Removal from the waiver those services that 1) are duplicative of state plan services, 2) have never been implemented, or 3) are no longer implemented as distinct services.

- Home and Community-Based Therapeutic Services (HBTS):
    - Moving Coordinated Specialty Care from Attachment B because it is not an HCBS.
    - Removal from the waiver of all other HBTS services because they are duplicative of state plan and other waiver services.

Rhode Island Executive Office of Health and Human Services

3 West Road | Virks Building | Cranston, RI 02920

The Secretary will hold two public hearings, as detailed below, at which times and places all interested persons therein will be heard on the above-mentioned matter.

Public Hearing #1	**Public Hearing #2**
April 4, 2024 5:00-7:00 p.m. Eastern Newport Public Library 300 Spring Street Newport, RI 02840 Also available for virtual participation: Zoom link: https://us02web.zoom.us/j/85755366505?pwd=d1RValJiNUdPT0N6WktoaUNPMmdFdz09 Zoom Dial-In: 888-788-0099 • Meeting ID: 857 5536 6505 • Passcode: 900653	April 11, 2024 1:00-3:00 p.m. Eastern 3 West Road Virks Building 1st Floor Training Room Cranston, RI 02920 Also available for virtual participation: Zoom link: https://us02web.zoom.us/j/83258100849?pwd=bW5wRllvTDZRRHlqdzhhRDJqcGtQUT09 Zoom Dial-In: 888-788-0099 • Meeting ID: 832 5810 0849 • Passcode: 288364

The proposed extension request addendum, formal public notice, and related materials are accessible for public review on the EOHHS website at https://eohhs.ri.gov/reference-center/medicaid-state-plan-and-1115-waiver/waiver-extension. In addition, the draft documents are also available in hard copy, located at the Security Desk on the 1st floor of the Virks Building at 3 West Road, Cranston, RI 02920.

Interested persons should submit comments to EOHHS on the proposed extension request addendum on or before April 15, 2024. Comments can be submitted via email to OHHS.RIMedicaidWaiver@ohhs.ri.gov or by mail to Amy Katzen, Executive Office of Health and Human Services, 3 West Road, Cranston, RI 02920.

If you have specific questions regarding this proposed extension request addendum or would like to schedule a tribal consultation to discuss the contents of the extension request addendum, please contact Amy Katzen via email at amy.katzen@ohhs.ri.gov or via phone at 401-462-6222.

Sincerely,

[redacted]

Richard Charest
Secretary
Rhode Island Executive Office of Health and Human Services